STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	15G313		LDING	00	12/14/	
NAME OF I			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIE				MISSISSIPPI ST		
ARC OF	NORTHWEST INC	DIANA INC, THE		HEBRO	N, IN 46341		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W0000		·					
	This wisit was f		W0	000			
This visit was for the investigation of Complaint #IN00119881.							
	Complaint #11vc	00117001.					
	Complaint #IN00119881:						
	•	TED, Federal and state					
	deficiencies rela	ated to the allegations are					
	cited at W102, V	W104, W122, W149,					
	W157, W240, W318, W331, W342 and						
	W346.						
	Unrelated defici	iency cited.					
	Dates of Survey and 14, 2012.	y: December 5, 6, 7, 10					
	Facility number	000832					
	Provider number						
	AIM number: 1	100249150					
	Surveyors:						
		, Medical Surveyor					
	III/QMRP-Team						
	Paula Chika, M	edical Surveyor III/QMRP					
	These federal de	eficiencies also reflect					
		accordance with 460 IAC					
	9.						
		mpleted 12/20/12 by Ruth cal Surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUILDING B. WING	00	COM	PLETED 4/2012			
ARC OF	PROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
ARC OF (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			N SHOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ211

Facility ID: 000832

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/14/2012		
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST	•	
ARC OF	NORTHWEST INDI	ANA INC, THE			DN, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0102	The facility must a governing body a requirements are Based on observer record review, the Condition of Body for 2 of 3 s. B). The governing the facility imples procedures to proving regard to a program of a client who had governing body facility put corresprevent recurrence a client who had governing body facility's nursing care needs of client ursing services meet the health of and to conduct quassessments. The to ensure the fact of a Registered Noversee the Licenstaff to ensure the were met. Findings included. 1. The governing the facility met to the same of the facility met to the same of the facility met to the facility met to the same of the facility met to the facility	met. ation, interview and be facility failed to meet Participation: Governing sampled clients (A and ang body failed to ensure emented its policy and event neglect of client A ressure ulcer. The failed to ensure the ctive measures in place to ace of pressure ulcers with history of ulcers. The failed to ensure the services met the health tent A, and to ensure trained facility staff to rare needs of the client uarterly nursing the governing body failed faility obtained the services for services and facility staff to the governing body failed faility obtained the services for services f	WO	102	CONDITION- Please refer to to W122, W318, and W104	ag	01/04/2013

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Event ID: PSZ211

Facility ID: 000832

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN	G		12/14/2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	KOVIDEK OK SUITELEN			19038 N	MISSISSIPPI ST	
	NORTHWEST IND	·		HEBRO	N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEFELECT	DATE
	_	(A). The governing body				
	_	ent its written policies				
	and procedures to prevent neglect of a					
	_	o a pressure ulcer. The				
		failed to put in place				
	corrective measures to prevent recurrence					
	of ulcers. Please	e see W122.				
	2. The governin	g body failed to ensure				
	the facility met t					
	1	ealth Care Services for 2				
	of 3 sampled clients (A and B). The					
	•	failed to ensure the				
	, ,	Care Services met the				
	· ·	each client. The				
	1	failed to ensure the				
	1 0 .	Care Services trained				
	1	clients' health care				
	_	risk plans addressed all				
		eeds of clients including				
		s staff were to follow in				
	_	care and repositioning.				
		verning body failed to				
	, , ,	aff reported all health				
		-				
	concerns to nurs	ing starr and/or lical/health needs. The				
		failed to ensure nursing				
		and monitored the				
		edical needs at the group				
		cted quarterly nursing				
	assessments. Ple	ease see W318.				
	3 The governing	g body failed to ensure				
		met the healthcare needs				

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PRINTED: 01/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G313		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER			19038 N	DDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	failed to ensure a monitored the classessed a client place specific riscare needs of the staff documented on the Medication and completed sichecks. The govensure nursing staff to provide oulcers for client. The governing befacility's nursing quarterly nursing who did not requarterly nursing services wound care/pressing services wound care/pressing services. The governing befacility is nursing services would care/pressing services would care/pressing services healthcare needs ulcers. Please services services healthcare needs ulcers. Please services asservices as services as services as services as services and provided the consultation and practical nursing services healthcare needs ulcers. Please services as services as services as services as services as services as services.	ient's health needs, is pressure ulcer, put in a plant to meet the health is client, to ensure facility in Administration Record in Administration Record in assessments/body failed to ervices adequately trained eare/treatment of pressure in A. On a pressure the services conducted in assessments for client B in a nursing care plant. On a plant in a p					

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PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G313	A. BUILDING B. WING		COMPLETED 12/14/2012		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID PREFIX TAG	SUMMARY ST	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL	
ANDTLAN	OI CORRECTION	15G313		LDING	00	12/14/	
		100010	B. WIN		ADDRESS STREET	12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			DN, IN 46341		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
TAG W0104	A83.410(a)(1) GOVERNING BO The governing bo policy, budget, an the facility. Based on observate record review for (A and B), the governing body in regard to a present governing body in policy and operate facility to ensure corrective measure recurrence of present who had a history governing body in policy and operate facility to ensure services met the client A, and to estimate the client A and to estimate a facility stocare needs of the quarterly nursing governing body in policy and operate facility to ensure services met the client A, and to estimate a facility stocare needs of the quarterly nursing governing body in policy and operate facility to ensure services of a Regand oversee the I	dy must exercise general doperating direction over ation, interview and r 2 of 3 sampled clients overning body failed to policy and operating e facility to ensure the need its policy and event neglect of client A essure ulcer. The failed to exercise general ting direction over the the facility put ares in place to prevent essure ulcers with a client y of ulcers. The failed to exercise general ting direction over the the facility's nursing health care needs of ensure nursing services aff to meet the health client and to conduct a sassessments. The failed to exercise general ting direction over the facility obtained the gistered Nurse to consult Licensed Practical	W0	TAG			01/04/2013
	_	nsure the health needs of					
	clients were met.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING	00	COM	TE SURVEY MPLETED 14/2012	
		15G313	B. WING			14/2012
	PROVIDER OR SUPPLIER		19038 N	ADDRESS, CITY, STATE, ZIP C MISSISSIPPI ST DN, IN 46341	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Findings include	:				
	1. The governing general policy are over the facility implemented with procedures to prowho had a histor governing body measures to previously measures to previously measures. The ensure nursing so care needs of cliewere adequately care for client A. 2. The governing general policy are	ag body failed to exercise and operating direction to ensure the facility atten policy and event neglect of a client by of pressure ulcers. The failed to put in place tent potential harm and/or governing body failed to ervices met the health tents and to ensure staff trained to provide wound a Please see W149.				
	included correcti	to ensure its investigation ve/preventative measures ence for client A. Please				
	general policy ar over the facility met the healthca B. The governing general policy ar over the facility monitored the classessed a client place specific ris	g body failed to exercise and operating direction to ensure nursing services are needs of clients A and ag body failed to exercise and operating direction to ensure nursing services itent's health needs, as pressure ulcer, put in k plans to meet the health e client, to ensure facility				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G313	B. WIN	G		12/14/2	2012
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	+	DATE
		d medications correctly					
	on the Medication Administration Record						
	and completed skin assessments/body						
	_	verning body failed to					
	_	policy and operating					
		e facility to ensure					
		adequately trained staff					
		reatment of pressure					
	ulcers for client	A. Please see W331.					
	4. The governing body failed to exercise						
		nd operating direction					
	, ,	to ensure the facility's					
	1	conducted quarterly					
	_	ents for client B who did					
		rsing care plan. Please					
	see W336.	sing care plan. I lease					
	Sec W 330.						
	5. The governin	g body failed to exercise					
	general policy ar	nd operating direction					
	over the facility	to ensure nursing services					
	trained staff in re	egard wound					
	care/pressure ulc	eers for client A. Please					
	see W342.						
		g body failed to exercise					
		nd operating direction					
	-	to ensure a Registered					
		able for consultation and					
	oversight of the	Licensed Practical Nurses					
		ovided nursing services					
	to meet client A'	s healthcare needs in					
	regard to pressur	re ulcers. Please see					
	W346.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G313	A. BUILDING B. WING	00	COMP	COMPLETED 12/14/2012		
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE		
IAU	This federal tag relates to complaint #IN00119881. 9-3-1(a)	IAU			DATE		

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Event ID: PSZ211

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPLI	ETED
		15G313	B. WIN			12/14/2	2012
			J. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			DN, IN 46341		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
PREFIX	A83.420 CLIENT PROTECT The facility must exprotections require Based on record interview, the fact Condition of Part Protections for 1 (client A). The find implement its positive prevent neglect of client's pressure thistory of pressure neglected to prevent neglected to ensure successive ulcers.	CTIONS ensure that specific client ements are met. review, observation and cility failed to meet the ticipation: Client of 3 sampled clients facility neglected to licy and procedures to of client A in regard to the facility as the client had a refulcers. The facility vent potential harm and/or	W0	TAG	W122- CONDITION- Also for W 149 - The Arc NW policy for handling cases of Neglect and abuse Reviewed 2/15/12 does include "depriving client of medical care/treatment not providing adequate personal care" within definition of Neglect. As it is impossible to identify all the win which a person can be denimedical care/treatment the vagueness of the statement is appropriate. In addition to this policy a work instruction on the prevention a monitoring Pressure sores was developed on 12/7/12. This powill be revised further to include the identification of all at risk persons, identify methods of preventing skin break down for risk persons, and will identify measures to be taken for individuals being treated for slibreak down. It will be completed by 1/13/13 Also for W 157 – Investigation 18609 corrective/ preventative measures was completed on	I Ing a In its ays ed k and s blicy de or at kin ted	
	2. The facility fa	niled to ensure its			12/12/12. Recommendations were for the IDT to meet and		
	investigation inc				revise Client A's repositioning		
	_				plan. The IDT met on 12/12/1	2	
		ntative measures to			and revised the plan.		
	_	ce of pressure ulcers for			Beginning 12/12/12 The Beha		
	client A. Please	see W157.			Health Director or his designe		
			1		will review all investigations to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а. вил	LDING	00	COMPLI	ETED
		15G313	B. WIN			12/14/	2012
			J. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L Comment of the Comm			MISSISSIPPI ST		
ABC OF	NORTHWEST INDI	IANA INC. THE			N, IN 46341		
ARC OF	NORTHWEST INDI	IANA INC, THE		TIEBRO	7N, IN 4654 I		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
					ensure that Corrective and		
	This federal test	ralatas to samplaint			preventative measures are		
	_	relates to complaint			included in the conclusion. Th	e	
	#IN00119881.				Management review team		
	9-3-2(a)				reviewed a sample of		
					investigations on a quarterly ba	asis	
					to ensure compliance with poli	су	
					and procedures.		
					Also for W 331 Community		
					Services Nurse will assess a		
					client's injury/skin breakdown		
					within 24 hours of report. In th		
					event that the individual is at ri	sk	
					for skin break down a work		
					instruction on the prevention a		
					monitoring Pressure sores was		
					developed on 12/7/12. This po	-	
					will be revised further to includ	e	
					the identification of all at risk		
					persons, identify methods of	.	
					preventing skin break down for	r at	
					risk persons, and will identify		
					measures to be taken for		
					individuals being treated for sk break down. It will be complet		
					by 1/13/13. Client A's risk plar		
					was revised on 12/12/12.	'	
					To prevent further		
					oversight the quarterly Nursing	,	
					assessment was revised to	'	
					include monitoring of risk plans	,	
					It was also revised to include a		
					evaluation of the frequency of		
					future nursing assessments.		
					Work instructions for this nursi	ng l	
					assessment will be revised by	·	
					1/31/13.		
					The service coordinator will		
					monitor that quarterly nursing		
					assessments were completed	on	
					a quarterly basis.		
					Direct care staff were retrained	ı	

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PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CON A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/14/2012			
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE			
			on documenting medication changes on all clients' MARs following each medication changes on all clients' MARs following each medication change DSPs are to fax the to the nurse for review. To ensure future compliance all MARs are reviewed by the Community services nurse of monthly basis. Direct care staff were retrain on documenting on the skin assessments/body checks of 12/11/12. These documents to be faxed into the nurse on weekly basis for review and forwarded to the service coordinator. To ensure future compliance the service coordinator will track the completion of these forms to ensure that no skin assessment/body check is missed on a weekly basis. Also for 336 Quarterly nursing assessments for client B was completed on 12/8/12. All of clients nursing assessments also completed in December 2012. The quarterly Nursing assessment was revised to include monitoring of risk platt was also revised to include evaluation of the frequency of future nursing assessments. Work instructions for this nur assessment will be revised to 1/31/13. To ensure future compliance service coordinator will monithat quarterly nursing	MAR the n a ed n are a then e g s her were ns. e an of ssing y the			

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PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 12/14	LETED
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE	HEBRO	DN, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
				assessments were comple a quarterly basis.	ted on	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G313	B. WIN			12/14/	2012
ARC OF	PROVIDER OR SUPPLIER	ANA INC, THE	•	19038 I HEBRO	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0149	The facility must of written policies are mistreatment, neg Based on record interview for 1 of the facility negles written policy and neglect of a client pressure ulcers, put in place means the health care not ensure staff were provide wound of Findings include A review of the facility's in indicated:		W0	149	The Arc NWI policy for handlin cases of Neglect and abuse Reviewed 2/15/12 does include "depriving a client of medica care/treatment not providing adequate personal care" within definition of Neglect. As it is impossible to identify all the wain which a person can be denied medical care/treatment the vagueness of the statement is appropriate. In addition to this policy a work instruction on the prevention a monitoring Pressure sores was developed on 12/7/12. This powill be revised further to include the identification of all at risk persons, identify methods of preventing skin break down for risk persons, and will identify measures to be taken for individuals being treated for sk break down. It will be completed by 1/13/13	e al its ays ed and s licy e	01/04/2013
	Conclusion': Inc 18609: Allegation	cident Report Number: on: Neglect failing to ssessment sheets by staff					
	for consumer wo						
		orting the allegation: All					
	staff stated that they stopped doing skin						
	` ′	check sheets. (sic)					
	When notified th	at the wound healed by					

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PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL		
ANDILAN	OF CORRECTION	15G313		LDING	00	12/14/	
		136313	B. WIN			12/14/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			MISSISSIPPI ST IN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	started back doing the					
		n notified by MEMO on					
		ey should not have					
		ot supporting this					
		ect Support Professional					
	(DSP) #14] state	d that she didn't receive a					
		nurse regarding skin					
	assessment check	ksAll the staff that was					
	(sic) interviewed	stated that they were					
	under the impres	sion that they could stop					
	doing the skin as	ssessment sheets, because					
	the wound had h	ealed, until they received					
	a memo on 10/22	2/12 stated that they					
	shouldn't have st	op (sic) doing the skin					
	assessment sheet	ts and needed to start					
	backAll staff w	vas (sic) unaware of the					
	second injury un	til they receive (sic) a					
	memo on 11/8	The nurse [Licensed					
	Practical Nurse ([LPN] #1] stated that 'she					
	told a few people	e that she wanted to stop					
	the skin assessm	ent checks, but she didn't					
		taff to let them know that					
	she wanted to co						
	assessment check	ks.'"					
	Further review o	f the investigation record					
	indicated:	6					
	"Incident/Accide	ent Report' dated					
		9:00 A.MI was made					
		ident on this consumer					
		I sent him to the wound					
		2. While doing a routine					
		doctor found a 0.7 x 0.4 x					
	Joan Chock, the	и от лана и от ла					

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	TOF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED
	PROVIDER OR SUPPLIER		P. (12)	STREET A 19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	his left ischium (2012 staff was ir doing the skin as fail (sic) to docu findingsHe is name] in the wor ThursdayCaus Incident/Accider to a pressures (si incontinentance mobility What could prevent red Incident/Accider there was a mem regards to not red assessment sheet this consumer. It sheets had not be therefore assessment sheet (sic)Action tal intervention, refe briefly: Weekly staff treating per observing for sig to the nurse." Bureau of Devel Services (BDDS 11/8/12Date of 11/8/12Submit	being seen by [Physician and clinic every se of this at: Factors that can lead c) ulcer are (sic) and limited measure(s) do you think occurrence of this at?: Prior to this incident so sent out to the house in ceiving the skin as on a daily bas (sic) on The skin assessment een discontinued ments should have been so was done this would been prevent ken (treatment, errals, etc.) Describe wound clinic visits with doctors orders. Staff cans of infection and report opmental Disabilities) report dated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		he wound clinic for a					
		t. Staff at the wound					
		a routine body check and					
		x 0.1 cm pressure					
	wound on his left ischium (buttocks)."						
	^	ted 11/8/12Date of					
		12/12Submitted date:					
	11/16/12: "I (LF	PN #1) was made aware					
	of this incident o	on this consumer after					
	which I had sent	him (client A) to the					
	wound clinic on	November 8, 2012.					
	While doing a ro	outine body check the					
	doctor found a 0	.7 x 0.4 x 0.1cm pressure					
	wound on his lef	t ischium (buttock). On					
		2 staff was instructed to					
	· ·	ing the skin assessment					
		ff failed to document any					
		Plan to Resolve:					
	I -	elinic visits will occur.					
	1	rve for signs of infection					
		nurse. 8 staff were					
	_	e schedule and a (sic)					
		* *					
		ation is being conducted					
	1	Results will follow					
	_	Further review of the					
	_	iled to indicate a follow					
	up report with th	e results of the					
	investigation.						
		01					
		Sheet" dated 11/16/12:					
		s off duty from Nov.					
		ve no special instructions					
	concerning this o	consumer (client A) in					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	E SURVEY LETED 1/2012
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST DN, IN 46341	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	When (sic) I menthat I wanted to assessments but fail to get back to them know that it sheets were to be notice. There is says the other nuthouses when I'm the office. We at the house and clinecessary for the emergency." "Interview Fact of [LPN #2]: "I did instructions from regarding [clienthouse regarding sheet." "Interview Fact of [LPN #3]: "I wainstructions for [while central teaton 11/7/12, 11/8. "Interview Fact of [DSP #10] time have (sic) not hat got (sic) it. We got nurse on 11/10/1	A the nurse (LPN #1) A] or the Mississippi skin assessment check Sheet" dated 11/16/12: s not given any client A] skin check m nurse was out of office				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		15G313	B. WIN			12/14/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			AISSISSIPPI ST N, IN 46341		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDENCE NAME CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(sic) to go (sic) [client A] on Saturday,					
	Monday and We	dnesday. [Client A] (sic)					
	wound went awa	y. We got an e-mail					
	saying that the w	round was gone (sic) that					
		on 9/22/12 from the nurse					
	it was not stated	if the nurse wanted us to					
		kin assessment sheet					
	(sic). On 10/22/	12 that's (sic) when the					
	`	sic) e-mail saying we					
	,	c) skin assessment sheet					
		in. On the 11/10 (sic)					
	` ′	staff find (sic) out about					
		and meds. I was still					
	T -	A] for wound (sic) the					
	1 -	know (sic) about was					
		s right feet (sic). While					
	"	A] up from being (sic) his					
		(sic) I never saw a					
		(sic) the email was sent					
		Fore 11/10/12 [client A]					
	` ′	t red. I never saw a					
		s thinking it was because					
	1 '	rkshop for a long time					
		e (sic) wet sometime for					
	1 ' '	ving work. Also dealing					
		is (sic) doesn't like					
		at night. I wash [client					
		nim every night before					
		(sic) something on					
		d send and (sic) email.					
		(sic) about the wound					
		s just red. Staff was					
		ecause he would bed					
	(sic) soaking we	t coming home from					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE (A. BUILDING B. WING	OONSTRUCTION 00	(X3) DATE COMPI 12/14	LETED
	PROVIDER OR SUPPLIED		STREET 19038	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST ON, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION DATE
TAG	workshop." "Interview Fact [DSP #11] time had one sore and given notice to skin graph sheet his right foot who nurse knew about the house once wanother staff do looked at the cli day client didn't his behind. It was (sic) email about That's when we the sore with a rawhich started on again on 11/12/1 what was follow gave it to him on August we receid doing good on that he was released in the clinic. The nurse putting triple an sore."	Sheet" dated 11/16/12: 11:00 A.M.: "[Client A] d it healed, staff wasn't stop or keep going on with s. Client had a sore on nich was being treated and at it. Nurse only came to which was to watch a med pass and she ent (sic) foot. From that have a (sic) open sore on as a surprise when we got but the sore on his behind. were given orders to treat med called Cellerate a 11/10/12, and given 12, and 11/14/12, and that wed and given because I an the 10th the first day. In we (sic) a (sic) email on the client (sic) sore and ased from the wound the gave instructions on just tibiotic ointment on the Sheet" dated 11/16/12: 12:00 P.M.: "On Oct. 22 sic) With [client A]'s last	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
	needed to fill ou	all told that we the staff t an assessment sheet t A]'s wound. Once it was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	OLTIPLE CO	00	(X3) DATE COMPL		
ANDILAN	OI COMMECTION	15G313		LDING		12/14/	
		100010	B. WIN		ADDRESS CITY STATE ZIR CORE	12/17/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
		ed an email stating that it					
		hat staff did a great job.					
		ff concluded that [client					
		l a wound and the nurse					
		at we needed to continue.					
		s ago I was told by my					
		re needed to continue					
	_	t sheets and so I have.					
		ound that [client A] has					
		currently, I became aware					
		weeks (sic) ago after he					
	_	the wound clinic and we					
		I that staff were to apply					
		ndage every 3 days and					
		all times. The assessment					
		ven to the nurse through					
		nail. Any paperwork that					
		l staff and then put in a					
		desk (sic). All staff are					
	-	naking sure that the mail					
	_	hoever is working in the					
	mornings during						
		for workshop separates					
		envelopes and label (sic)					
		they go to. The mail is					
	_	range bag behind [client					
	A]'s wheelchair.	-					
	Mississippi is on	Thurs. from 10 p.mFri.					
	_	mSat. 8 a.m., Sat. 11					
	p.mSun. 8:30 a	.m I have done body					
	_	t A] prior to the weekend					
	of the 9th. When	n I came in that weekend					
	(of the 9th) to wo	ork he had already been					
	seen by the doc ((doctor) and we received					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE C	ONSTRUCTION 00	COM	TE SURVEY IPLETED 14/2012	
		100010	B. WING	ADDRESS STATE STATE STATE		1 1/2012
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C	CODE	
ARC OF	NORTHWEST INDI	ANA INC. THE		ON, IN 46341		
				T		(7/5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S.		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
	the instructions t	o apply the cream every 3				
		m dry at all times."				
	"Interview Fact S	Sheet" dated 11/16/12:				
	Group Home Le	ead (GHL)] at 1:00 P.M.:				
	_ ^	pt [client A] had a				
		s notified of following				
		ed topicals and bandage				
		note to follow. All was				
	11.	e (sic) staff received an				
	~ ~	ent A] was all healed up-				
	1 0 5	know that, body				
		struction was given from				
	-	few days nurse was				
		nily checklist and we did				
		otice. My shift time (sic)				
		m5 p.m. to 10:45 p.m. 5				
		ek sheets are sent daily in				
	1 '	es which is (sic) directed				
	_	ff is (sic) responsible for				
		to Main (main office). I				
	1	memo but was informed				
	by the nurse to c	ontinue body checklist.				
	*	ent [client A] had a				
	wound due to his	s visit at the wound				
	check. I did not	do a body check sheet				
	because the pers	on who was taking care,				
	did them early in	•				
	_	printed out, med memo				
		any information in the				
		book- also there is a (sic)				
		for staff to read daily.				
) require signing. I don't				
	recall having to	sign any memo on [client				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN			12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	- I	DATE
	A]. I think we n	· ·					
		not just by email but					
	maybe a personal visit by the nurse-she only communicate (sic) to the house and						
	_	client A]- a phone					
		nunication may be stop					
		inication (sic). As far as					
		are doing a great job and					
	best at their job (
	computer slow- and staff has help (sic)						
	me a lot. Also I was told to send so many e-mail (sic) a week to complete."						
	e-maii (sic) a we	eek to complete.					
	"Interview Fact	Sheet" dated 11/16/12:					
		5 P.M.: "I worked on					
		P.M. one day a week. I					
		about 2 or 3 months ago					
		ding the assessment sheet					
		A] from head to toe every					
	-	[client A] on the night I					
	(sic) when he car						
	` '	when it was time for him					
	• •	id not notice any unusual					
		cept the one on his right					
		s already sent in to the					
	nurse (sic) when						
	, ,	turn in assessment check					
		mail and put in out					
		When received memo					
		s clearing. I was under					
		ve have to do assessment					
	-	A] when a memo stating					
	-	-					
	started assessme	•					
	we were not to s	top assessment when I					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		eryday as soon as you					
	come in check emails, communication						
	,	mation book. It's (sic) not					
	-	se stating that you should					
		memo when need it.					
	When I came to	work last Wed. I was					
	informed that [cl	ient A] had a new wound					
	and we should p	ut his cream on it."					
	"Interview Fact S	Sheet" dated 11/16/12:					
	[DSP #13]: "I w	ork Mon, Tues, Wed.					
	10:00 P.M. to 8:	30 A.M No I have not					
	observed any wo	ounds on [client A]. Yes I					
	do recall seeing	a skin check memo on					
		n September. I do recall					
		to the wound clinic and					
		care of. I was told that					
		vent to wound clinic that					
		ontinue putting bandage					
		nce I am done with skin					
		eft on desk with daily					
		heet. No there is not a					
		ading memo (memos are					
	^	nd left for staff to read in					
	J 1						
		e only marks (sic) that I					
	=	ient A] was documented					
		anytime while working					
		have seen any new marks					
		ed per investigator he					
		t he didn't do anymore					
		checks after the first					
	womb (sic) heale	ed on 10/22/12."					
	"Interview Fact S	Sheet" dated 11/16/12:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G313	B. WIN	G		12/14/2	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e interview: "[DSP #14]					
works Sat. and Sun. 7 A.M11 P.M							
	-	d that 'She did receive a					
		nurse regarding checking					
	him (client A) or	n the skin assessment					
	sheet.' [DSP #14] said that she stop (sic)					
	doing the skin as	ssessment sheet because					
	the woumb (sic)	was healed. She started					
	back once it was	reported on 11/8 to start					
	back doing the s	kin assessment sheet."					
	"Interview Fact	Sheet" dated 11/16/12:					
	[DSP #15]: "Sur	nday 11/11/12-I worked					
	-	om 8:30 A.M. til 10 P.					
		er staff if anyone need					
		ny work need to be done					
		to church. Only work to					
		Sunday, did not do skin					
		k. Any noticible (sic)					
		conducted (sic), fill out					
		t then either fax it to the					
		to the nurse. Did not see					
		ed by co-worker about the					
		not remember when I					
	received the info						
	received the into	nnauvii.					
	Further review o	of the investigation record					
		i inc mivestigation record					
	indicated:						
	"Conclusion: Do	arts of this allegation is					
		•					
		aff forgot to do skin					
		ks. The nurse [LPN #1]					
		her instructions to staff					
	regarding the ski	in assessment checks.					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/14/2012
	PROVIDER OR SUPPLIED		19038	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST ON, IN 46341	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	discontinue check the wound was la 22, 2012 (sic). (sic) that they we continue skin as email dated 10/2 should have come assessment check Skin assessment Further however the area in this is system for ongoing conditions needs investigation in signed and dated administrator or review of the invindicated the fact as of 12/7/12 who measures/recome actions would be potential harm as a An evening obset the group home P.M. until 8:10 to observation periods wheelchair for mencouraged and alternate surface. A review of clief	mendations/corrective e put in place to prevent nd/or recurrence. ervation was conducted at on 12/5/12 from 5:10 P.M During the entire od client A utilized a nobility and was not /or redirected to an			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN	G		12/14/2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
ABC OF	NODTHWEST IND	IANIA INIC. THE			MISSISSIPPI ST N, IN 46341	
	NORTHWEST IND				IN, IIN 4034 I	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		2 at 11:22 A.M Review		_		
of client A's wound clinic records						
		a history of pressure				
		to 9/20/12. Review of				
	the Wound Clini	ic records indicated the				
	following:					
	Wound clinic no	otation dated 9/20/12:				
	"Wound Clinic:	Now healing wound left				
	ischial and groin	wounds now healed."				
	Wound clinic no	otation dated 11/8/12:				
	"Wound Clinic:	Left ischial wound0.7				
	x 0.4 x 0.1cm9	90% pink 10%				
	yellowFoot- 0.	.7 x 0.3 x				
	0.1Non-healin	g left ischial wound and				
	right heel wound	d." Further review of the				
		indicate any nursing				
		the size, shape and color				
		nanging of dressing or				
		by facility nursing staff of				
	client A's wound	1.				
	W7 1 1' '	4-4: 4-4-4 11/15/10				
		otation dated 11/15/12:				
	"Wound Clinic:	•				
	ischial wound 0.	heel scabbed overleft				
		e to ischial wounds every				
		n in 1 week." Further				
		cord failed to indicate any				
		ment of the size, shape				
	_	wound, changing of				
		mentation by facility				
		client A's wound.				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
		15G313	B. WING	ING		12/14/	2012
	PROVIDER OR SUPPLIEI			19038 M	DDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	"Wound Clinic: woundsleft isc 0.1cmCellerate other dayreturn pressure ulcer." record failed to reassessment of of the wound, che documentation be client A's wound. The 11/29/12 Para Details sheet (plindicated "Woun Remove old drewith normal salic clean dressing untissues or cotton use excessive for sponges, not tiss Protect wound a shower. Keep de Change dressing Cellerex applied new ointment ear Multi Wound Clear Wound Location Type: Pressure 7/12/12. Wound	thial wound 0.6 x 0.4 x te to ischial wound every in in 1 weekstage 2 Further review of the indicate any nursing the size, shape and color ranging of dressing or ranging of dressing: ranging of dressing or ranging of dressing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G313	B. WIN	_		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			MISSISSIPPI ST IN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
	A review of the group home Medication Administration Record (MAR) book was						
conducted on 12/5/12 at 6:00 P.M							
	Review of the re	ecord indicated:					
	"Health and Saf 10/31/12, from I staff: "Please h [client A]'s right foot with peroxi antibiotic ointmo on the area. Kee skin begins to be immediately."	fety Memo" dated LPN #1 to group home andle the treatment for foot as follows: Cleanse					
I	from LPN #1 to	group home staff: seen at the wound clinic					
	_ =	nds. One on his right foot					
	1 -	is left buttocks. He came					
		llowing orders: For the					
	right foot wound	d: Aquacel dressing					
	applied to woun	d-DO NOT REMOVE					
		G- Do not get the dressing					
	wet-Cover the d	•					
	_	e left ischial (buttocks)					
		x applied today by wound					
	_	ea clean and dry. Cover					
		New Cellerex to be					
		her day, starting Saturday,					
		ove dressing, pat wound					
		ze, then pat dry with a NOT WIPE OFF THE					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE C	ONSTRUCTION 00	COM	E SURVEY PLETED 4/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP (2012
ARC OF	NORTHWEST INDI	ANA INC, THE	HEBR	ON, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	of Cellerex and of dressing. Keep a while bathing. T OTHER DAY (S Wednesday) he'l clinic on Thursda "Health and Safe 11/30/12 from L	•				
	his right foot and buttocks (sic). He following orders wound: This are the left ischial (be applied on 11/29 area clean and do New Cellerex to day. Remove dre damp gauze, and gauze. DO NOT MEDICATION. Cellerex and cover	ay for 2 wounds. One on a lone above his left le came back with the le came back with the le For the right foot la has been resolved. For luttock) wound: Cellerex by wound clinic. Keep le cover while bathing, be applied every other lessing, pat wound with lethen pat dry with dry le WIPE OFF THE OLD le Apply new layer of le with a clean dressing. Le of the Cellerex please lorder. Please call with				
	12/5/12 at 6:00 F current MAR dat 12/31/12. Revie	f the record conducted on P.M., indicated a most ted 12/1/12 until w of the MAR indicated: pintment: Bactroban 2%				

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	OF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 12/14	
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 N	ADDRESS, CITY, STATE, ZIP COD MISSISSIPPI ST DN, IN 46341	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	ointmentApply to wound topically once daily as directed." Further review indicated this medication was administered on 12/1/12, 12/3/12, 12/4/12 and 12/5/12. This medication was not administered on 12/2/12. The record failed to indicate which wound this ointment was to be applied to. Further review of the MAR did not have Cellerex, saline solution and gauze squares listed on MAR. The record indicated a most current "Health Risk Plan" for client A dated 1/17/12 which indicated: "Client is at risk for skin breakdown related to incontinence and decreased activity. Client is allergic to adhesives which can result in skin irritation. Client is a heavy wetter. Repositioned (sic) client every 4 hours and as needed. Position in another chair if possible. Check for incontinence every two hours and change as needed. Encourage client to change positions frequently. Apply treatment as ordered. Notify nurse of changes in skin condition immediately, if area becomes reddened, opens, bleeding, or irritated. Encourage client to use the bathroom every 2 hours during the day and at night. IDT (Inter Disciplinary Team) to review plan quarterly and revises as needed. Ensure client is using the correct size undergarment to avoid contact with adhesives. Service Coordinator to monitor behavior logs monthly and revise				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUILDIN		NSTRUCTION 00	(X3) DATE S COMPL 12/14/	ETED	
		100010	B. WING	P. P. P. P. A.		12/11/	2012
NAME OF I	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC. THE			N, IN 46341		
						-	(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		e to monitor incident and					
		and revise as needed."					
	decident reports	and revise as needed.					
	On 12/6/12 at 3::	37 P.M. SC #1					
submitted a 5/12 "Repositioning Risk Plan". The 5/12 risk plan indicated;							
	"[Client A] had a	-					
		ue to these conditions					
		sk for skin breakdown					
		pility and incontinence.					
Baseline: [Client A] currently spends							
almost all the time he is awake in his							
		d. He needs to be					
		f his chair and/or bed to					
		on his back/buttocks as					
	_	ge muscle movement."					
	_	an indicated: "Staff are to					
	notify the Nurse						
	1	ny redness, openings or					
		eved." The 5/12 risk plan					
	_	cate any additional					
	_	egard to how facility staff					
		the client's wound and/or					
		ound was to be kept dry					
	during showers.	ound was to be kept dry					
		2 risk plan also neglected					
	1	the facility reviewed and					
		lient's risk plan to ensure					
	the client's woun	-					
	uie chem s woun	iu care needs.					
	The Individue! S	unnart Dlan (ISD) datad					
		upport Plan (ISP) dated d client A was at risk for					
		Client A's record					
	neglected to indi	cate a					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE SU COMPLET	
AND PLAN	OF CORRECTION	15G313	A. BUILDII	NG	00	12/14/20	
		100010	B. WING	TDEET A	DDRESS, CITY, STATE, ZIP CODE	12/11/20	712
NAME OF P	PROVIDER OR SUPPLIER	l .			IISSISSIPPI ST		
	NORTHWEST INDI				N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION DATE
1110		ernative seating schedule					
		nt potential injury. The					
		to indicate a current					
Physical Therapy (PT) assessment. The							
		to indicate the facility					
	obtained client A	•					
	assessment. The						
	"Nutritional Ass	essment" was dated					
	8/21/11. Client	A's record neglected to					
	indicate the IDT	met regarding client A's					
	wound care.						
	A review of the	group home daily					
	progress notes da	ated 9/1/12 to 11/30/12					
	was conducted o	n 12/6/12 at 1:15 P.M					
	•	ogress note indicated:					
	"Ate breakfast, s	howered took a.m. meds.					
		l t.v. after goals. After					
	lunch, hygiene, t	ook noon med, took a					
	-	anged for dinner, sore on					
		ed. He clean (sic) for					
		edtime) meds, went to					
	•	him every two hours					
		needed." Further review					
	indicated no doc						
	•	/1/12, 11/7/12, 11/8/12,					
	•	2, 11/17/12, 11/18/12,					
	· ·	112, 11/23/12 and					
	11/30/12. Revie						
		cate group home staff					
	-	medical status in regards					
	to client A's wou	ina aany.					
	A review of the	facility's group home staff					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G313	B. WIN	G		12/14/	2012
NAME OF F	PROVIDER OR SUPPLIEF	\			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIO TUE			MISSISSIPPI ST		
	NORTHWEST IND				N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		was conducted on	+	1710			DATE
		P.M Review of the					
	8/15/12 "Wound Care Training"						
		icate DSP #2, DSP #12					
	_	d been trained in regards					
		The facility neglected to					
		dditional training in					
	_	d care since 8/15/12.					
	regards to would	u care since 6/13/12.					
	An interview wi	th DSP #2 was conducted					
	at the group home on 12/5/12 at 6:18						
		.M DSP #2 indicated					
		d treatments to the wound					
		on Mondays, Wednesdays					
		bedtime. DSP #2					
	1	client was wet they would					
		age when he was toileted.					
	_	vas asked if staff at the					
		e applying the Cellerex or					
		ent A's wound, DSP #2					
	_	llerex was being applied.					
		at the Mupirocin was					
		red for, DSP #2 indicated					
	1	ras applied to client A's					
	wound.	as applied to elicit A's					
	would.						
	An interview wi	th the group home Team					
		conducted at the group					
	` ′	2 at 6:47 P.M The TL					
		ex was being applied to					
		d. When asked what					
		peing applied to, the TL					
	_	om." When asked if the					
		he same as the Cellerex,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN	G		12/14/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL WATER IND	IANIA INIC. THE			MISSISSIPPI ST	
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	l `	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		m not sure." When asked		TAG		DATE
to see the Cellerex and the Mupirocin, DSP #2 and the group home TL were not						
	able to locate the medications in the					
		eabinet until 7:15 P.M				
		edication ointment tube				
		lear plastic bag, which				
		ged gauze squares. The				
		t labeled. The Mupirocin				
		_				
was found in a labeled box which indicated it was to be applied topically to						
	wound once dail					
	woulld offee dair	у.				
	 Confidential inte	erview C stated client A's				
	wound "was the					
		erview C stated client A's				
		little open." When				
		rview C was asked how				
		wound area was changed,				
		rview C stated "Every				
		heck when he is toileted				
	<u>-</u>	en given shower and				
		idential interview C also				
		se square gauze and tape.				
		en the staff was trained in				
		care, confidential				
	_	"I read a memo."				
		erview C indicated she				
		e training because she				
		of the training held about				
		When asked how often				
	_	o the group home,				
		rview C stated "I have				
		t this group home."				

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	î î	TE SURVEY IPLETED
		15G313	A. BUILDING B. WING			4/2012
				ADDRESS, CITY, STATE, ZIP C	CODE	
NAME OF F	PROVIDER OR SUPPLIER	₹		MISSISSIPPI ST		
	NORTHWEST IND		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL S LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)		COMPLETION DATE
1710		v does the nurse know	1710			DATE
		oks like, confidential				
		ed "Good question, we				
		raph sheets that only				
	_	t is. We write more				
		he daily log sheets."				
		erview C indicated client				
		ned out of his chair when				
	_	and some time after he				
	-	would take him out of his				
	wheel chair and	he was placed on the				
	couch. When as	sked if staff documented				
	when client A w	as taken out of his				
	wheelchair, cont	fidential interview stated				
	"No."					
	An interview wi	th Service Coordinator				
		iducted on 12/5/12 at 7:10				
	` ′	2 at 3:55 P.M The SC				
		llerex was not on the				
		1/12 to 12/31/12. When				
		d what the Mupirocin				
		ed to, the SC stated "I				
		ne SC indicated the				
	Cellerex should	be listed on the MAR and				
	the staff should	document when the				
	Cellerex is being	g applied. At that time				
	the SC made a p	hone call. When she				
	returned she ind	icated the nurse had				
	previously told t	the staff to discontinue the				
	_	urther indicated the				
	_	ld not be on the MAR.				
		d staff were probably				
	applying the Cel	llerex but were				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO	ONSTRUCTION 00	COMI	E SURVEY PLETED 4/2012	
	PROVIDER OR SUPPLIER		19038	ADDRESS, CITY, STATE, ZIP O MISSISSIPPI ST DN, IN 46341		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
IAU	documenting the SC then instructed the Cellerex was should contain the staff could not loo #1 indicated LPN meeting in regard wound care at the 2012. SC #1 fur no documentation mentioned meeting client A's IDT has and/or address client A's IDT has and/or address client and/or address client and/or address client and/or recurrence with a put in place to propose and/or recurrence. An interview with at the facility's at 12/6/12 at 10:38 she was not awards.	Mupirocin instead. The ed staff to go find the box in which she indicated he label. The group home ocate a box or a label. SC N #1 had conducted a ds to pressure ulcers and he beginning of November ther indicated there was not in regards to the hig. SC #1 indicated had not met to review hient A's identified he ulcer. SC #1 further for neglected to ensure the research safeguards were reverted to go find the box in the high safeguards were reverted to go find the box in	IAG	DETCENCT)		DATE
	care. When aske	ed if the facility had a o contact a nurse, LPN				
	administrative of P.M LPN #1 and A had a pressure	ch LPN #1 - conducted at the facility's ffice on 12/6/12 at 2:26 and SC #2 indicated client culcer on his buttocks. d client A had a history				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G313	B. WIN			12/14/2	2012
NAME OF P	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODELIMEST IND	IANIA INIC. THE			MISSISSIPPI ST		
	NORTHWEST IND			HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		rs as the client had a		IAG	,		DATE
	•	hich healed on 9/20/12.					
	1 ^						
	When asked how many wounds/areas client A was being treated for prior to						
		dicated client A had a					
		attocks. When LPN #1					
		1/12 "Nursing Quarterly					
		PN #1 stated "Oh, he had					
	·	N #1 indicated client A's					
	current pressure ulcer reappeared 11/8/12 as the ulcer was found at the wound						
	clinic while being treated for a pressure						
	ulcer to his foot.						
		e applied to [client A's]					
		** .					
		rd day, Mondays,					
	1	l Saturdays." When					
	_	pirocin was used for, LPN					
		ot sure what that is being In LPN #1 reviewed the					
		ysicians orders dated					
		/29/12, LPN #1 then					
		llerex should be applied					
	•	and further indicated be on the current MAR.					
		d the wound care nurse					
		erex should be applied					
	on Mondays, W						
	1	en LPN #1 was asked if					
	· ·	tated "No." LPN #1					
		ound care clinic nurse told					
	1	need to use the normal					
		or client A's wound.					
	When asked if L	rn #1 sougnt					

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PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/14 .	ETED	
		100010	B. WIN	_		12/17/	2012
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		n the attending physician					
		e wound care clinic					
	l '	tated "No." When asked					
		e and gauze square were					
		ame thing, LPN #1 stated					
		nere are only gauze					
	•	ouses." LPN #1 then					
	_	not the same." When					
		had observed staff doing					
		tment at the group home,					
	LPN #1 indicate						
	treatments prior to 11/8/12. When asked						
	if LPN #1 had seen client A's current						
		8/12, LPN #1 stated "No					
		e not been there yet."					
		w big client A's pressure					
		#1 stated "About the size					
	of a quarter." L	PN #1 indicated she was					
		e the size by reading					
	client A's wound	d clinic notation dated					
	11/29/12. When	LPN #1 was asked how					
	often she went to	o the group home to					
	assess clients, sh	ne stated "I was going					
	quite often, but i	now I have slacked."					
	LPN #1 indicate	d she assessed the clients					
	every three mon	ths at the day program.					
	LPN #1 indicate	d skin assessments were					
	to be done by gr	oup home staff twice a					
	day. LPN #1 ind	dicated the facility staff					
	were to send in t	the skin assessment					
	sheets daily. LP	N #1 indicated the skin					
	assessment shee	ts did not give any					
	information/deso	cription of the client's					
	wounds, they on	ly indicated the location					
	l .						<u> </u>

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Event ID: PSZ211

Facility ID: 000832

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MUL' A. BUILDI B. WING		00	COM	ie survey ipleted 14/2012
	PROVIDER OR SUPPLIED			19038 M	DDRESS, CITY, STATE, ZIP COD IISSISSIPPI ST N, IN 46341	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	who documents medications on "Lead or staff." to make sure the correctly, LPN (MAR) to make #1 indicated she 12/2012 MAR. staff keep the dr showering, LPN "covering with swas told." LPN no written proto to ensure the word and SC #2 indicated client neglected to spe the client should what alternate so LPN #1 and SC clinic ordered a hospital bed for pressure ulcers. indicated client cushion and bed LPN #1 and SC the adaptive equicated staff was settings on the best correctly to make a sure of the sure of the staff was settings on the best correctly.	the physicians orders and the MAR, LPN #1 stated When asked who checks when asked who checks when asked it is correct." LPN when asked how does we will be a stated when asked how does we will stated staff were saran wrap from what I will indicated there was wool for client A's wound bound stayed dry. LPN #1 and SC #2 A's program plan we ficially indicate when the propositioned and/or surface should be utilized. #2 indicated the wound ROHO cushion and a client A due to his LPN #1 and SC #2 A received a ROHO on Monday (12/5/12). #2 indicated the use of a might be plan. LPN #1 stated was "electrical" and further were not to change the bed. When asked if staff d on the use of the bed,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CONSTRUCTION A. BUILDING OO			(X3) DATE SURVEY COMPLETED 12/14/2012		
		15G313	B. WIN			12/14/	2012
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			MISSISSIPPI ST DN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		Not sure. I did not train					
		indicated facility staff					
	did not documer						
		egards to client A's					
		status. LPN #1 indicated					
		have a current PT					
		eelchair assessment or					
		sment in regards to client					
		needs. When asked if					
	client A had an updated risk plan for skin						
	breakdown, LPN #1 stated "I don't know,						
		ess to risk plans." When					
	asked if nursing	staff were involved and					
	had input in the	development of medical					
	risk plans for cli	ents, LPN #1 stated "No,					
	the SC write all	risk plans for all clients."					
	When asked if the	he facility had a					
	Registered Nurs	e available for oversight,					
	LPN #1 and SC	#2 stated "No." When					
	asked who was j	providing oversight and					
	direct supervision	on over the facility's LPN					
	staff, LPN #1 sta	ated "[Group Home					
	Services Directo	or name (GHSD)]."					
	When asked if the	he GHSD was a RN,					
	LPN #1 stated "	-					
	An interview wi	th the facility owned day					
		e Coordinator (SC) and					
	` •	rect Support Professional					
		conducted on 12/7/12 at					
		program SC indicated					
	the facility had i						
		ternative seating schedule					
		staff to document for					
	1						<u> </u>

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		licated the day program					
		A out of his wheelchair					
	-	a bean bag because					
	_	ins of pain. When asked					
		A complained of pain,					
	day program SC	asked day program DSP					
	#1 who stated "	Several times a day, he					
	states it feels like	e a needle. "					
	An interview with client A was						
	conducted on 12/7/12 at 2:20 P.M						
	Client A indicate	ed he stays in his					
	wheelchair until he goes to bed.						
	A review of the	facility's "Policy for					
	Handling Cases	of Neglect and Abuse"					
	dated 12/20/06 v	vas completed at the					
	facility's adminis	strative office on 12/5/12					
	at 2:30 P.M., and	d indicated: "In order to					
	protect the gener	ral welfare of the clients,					
		Indiana has in effect the					
	following policy	with regard to abuse,					
		itation of clients by					
		ohibits all abuse, neglect					
		of our clientsStaff will					
	-	ort any allegations of					
		r exploitation of our					
	clients per agenc	-					
	procedureNegl						
		ng a client in a situation					
	-	at to his/her health and					
	_	mples include, but are					
		epriving a client of food,					
	clothing, shelter	or medical care."					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY TPLETED 14/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET A 19038 M HEBRO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	This federal tag relates to complaint #IN00119881. 9-3-2(a)				

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLE	TED
		15G313	B. WIN			12/14/2	012
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		19038 1	MISSISSIPPI ST		
	NORTHWEST INDI	IANA INC, THE		HEBRO	DN, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG W0157		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
VVU157	483.420(d)(4)	ENT OF CLIENTS					
		ation is verified, appropriate					
	corrective action must be taken.						
	Based on intervi	ew and record review for	W0	157	Investigation 18609 corrective	/	01/04/2013
	1 of 4 allegations	s of abuse, neglect and/or			preventative measures was		
	injuries of unkno	own source reviewed, the			completed on 12/12/12.		
	_	ensure its investigation			Recommendations were for th IDT to meet and revise Client		
	1	ive/preventative measures			repositioning risk plan. The ID		
		rence for client A.		met on 12/12/12 and revised			
	r				plan.		
	Findings include	•			Beginning 12/12/12 The Beha		
	A review of the facility's records was				Health Director or his designee will review all investigations to		
					ensure that Corrective and		
		facility's administrative			preventative measures are		
		2 at 12:45 P.M Review			included in the conclusion. Th	ne	
		nvestigation records			Management review team		
	I	_			reviewed a sample of investigations on a quarterly b	asis	
		lowing regarding client			to ensure compliance with poli		
	A:				and procedures.		
	"Invectigation E	act Sheet: Summary and					
	_	act Sheet: Summary and					
		eident Report Number:					
		on: Neglect failing to					
		ssessment sheets by staff					
	for consumer wo						
	1	orting the allegation: All					
		hey stopped doing skin					
) check sheets. (sic)					
		at the wound healed by					
	_	started back doing the					
		en notified by MEMO on					
	10/22/12 that the	ey should not have					
	stoppedFacts n	ot supporting this					
	allegation: [Dire	ect Support Professional					
	(DSP) #14] state	ed that she didn't receive a					

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Facility ID: 000832

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	OF CORRECTION OF CORRECTION 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/14/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	memo from the nurse regarding skin assessment checksAll the staff that was (sic) interviewed stated that they were under the impression that they could stop doing the skin assessment sheets, because the wound had healed, until they received a memo on 10/22/12 stated that they shouldn't have stop (sic) doing the skin assessment sheets and needed to start backAll staff was (sic) unaware of the second injury until they receive (sic) a memo on 11/8The nurse [Licensed Practical Nurse (LPN) #1] stated that 'she told a few people that she wanted to stop the skin assessment checks, but she didn't get back to the staff to let them know that she wanted to continue the skin assessment checks."" Further review of the investigation record indicated: "Incident/Accident Report' dated 11/12/12Time 9:00 A.MI was made aware of this incident on this consumer after which I had sent him to the wound clinic on 11/8/12. While doing a routine body check, the doctor found a 0.7 x 0.4 x 0.1 cm (centimeter) pressure wound on his left ischium (buttock). On Oct. 22, 2012 staff was instructed to continue with doing the skin assessment sheets. Staff fail (sic) to document any wound findingsHe is being seen by [Physician			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G313	B. WIN	G		12/14/20	012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	name] in the wor	•					
	ThursdayCaus						
Incident/Accident: Factors that can lead							
	to a pressures (si	c) ulcer are					
	incontinentance	(sic) and limited					
	mobilityWhat	measure(s) do you think					
	could prevent re-	occurrence of this					
	Incident/Acciden	nt?: Prior to this incident					
	there was a mem	o sent out to the house in					
	regards to not re	ceiving the skin					
	assessment sheets on a daily bas (sic) on						
	this consumer.	The skin assessment					
	sheets had not be	een discontinued					
		nents should have been					
		s was done this would					
	(sic) could have						
	(sic)Action tal	•					
	` ′	errals, etc.) Describe					
		wound clinic visits with					
	· ·						
	_ · ·	doctors orders. Staff					
		gns of infection and report					
	to the nurse."						
	Duranu of Do1	anmental Disabilities					
		opmental Disabilities					
	Services (BDDS	*					
	11/8/12Date of	•					
		ted Date: 11/9/12:					
		on scheduled medical					
		he wound clinic for a					
		t. Staff at the wound					
		a routine body check and					
		x 0.1 cm pressure					
	wound on his lef	t ischium (buttocks)."					

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Event ID: PSZ211

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ted 11/8/12Date of					
		12/12Submitted date:					
	11/16/12: "I (LPN #1) was made aware						
		on this consumer after					
		him (client A) to the					
	wound clinic on	November 8, 2012.					
	While doing a ro	outine body check the					
	doctor found a 0	.7 x 0.4 x 0.1cm pressure					
	wound on his lef	t ischium (buttock). On					
	October 22, 2012	2 staff was instructed to					
	continue with do	ing the skin assessment					
	sheets which stat	ff failed to document any					
	wound findings	Plan to Resolve:					
	Weekly wound o	elinic visits will occur.					
	1	rve for signs of infection					
		nurse. 8 staff were					
	_	e schedule and a (sic)					
		ation is being conducted					
	_	Results will follow					
	1	Further review of the					
	_	ailed to indicate a follow					
	up report with th						
	investigation.	ic results of the					
	mivestigation.						
	Further review o	f the investigation record					
	indicated:	i the myestigation record					
	muicateu.						
	"Conclusion: Do	arta of this allogation is					
		orts of this allegation is					
		aff forgot to do skin					
		ks. The nurse [LPN #1]					
		her instructions to staff					
	1 -	in assessment checks.					
		aff to continue or					
	discontinue chec	king the buttock. Once					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G313	B. WIN	G		12/14/2	012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nealed around September					
		Therefore, staff assume					
	` ′	asn't suppose (sic) to					
		sessment checks until the					
		2/12 stated that they					
		tinue (sic) doing the skin					
		ksRecommendations:					
		s were completed.					
		, not showing anything in					
	the area in this in	nvestigation (sic). A					
	system for ongoing	ing wounds and other skin					
	conditions needs	to be discussed." The					
	investigation ind	licated the document was					
	signed and dated	by the facility's					
	administrator on	11/16/12. Further					
	review of the inv	vestigation record					
	indicated the fac	ility failed to indicate as					
	of 12/7/12 what						
	measures/recom	mendations/corrective					
	actions would be	e put in place to prevent					
	potential harm as	nd/or recurrence of					
	pressure ulcers f	or client A.					
	•						
	An interview wi	th Service Coordinator					
	(SC) #1 was con	ducted on 12/5/12 at 7:10					
	P.M. and 12/6/12	2 at 3:55 P.M SC #1					
	indicated LPN #	1 had conducted a					
	meeting in regar	ds to pressure ulcers and					
	wound care at th	e beginning of November					
	2012. SC #1 fur	ther indicated there was					
	no documentatio	n in regards to the					
	mentioned meeti	ing. SC #1 indicated					
	client A's IDT ha	ad not met to review					
	and/or address c	lient A's identified					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G313	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	PLETED 4/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 1	ADDRESS, CITY, STATE, ZIP MISSISSIPPI ST DN, IN 46341	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		15G313	B. WIN			12/14/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			DN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0240	relevant intervent individual toward Based on observer record review for (A), the client's I (IPP) failed to in facility staff were to prevent skin be ulcers and/or how wound dry when Findings include A review of client conducted at the office on 12/6/12 of client A's wou indicated he had ulcers from 3/12 the Wound Clinic following: Wound clinic no "Wound Clinic: ischial and groin Wound Clinic: x 0.4 x 0.1cm9 yellowFoot- 0.	ogram plan must describe ions to support the independence. ation, interview and r 1 of 3 sampled clients individual Program Plan dicate how and/or when e to reposition the client reak down/pressure w to keep the client's showering. The A's record was facility's administrative 2 at 11:22 A.M Review and clinic records a history of pressure to 9/20/12. Review of c records indicated the tation dated 9/20/12: Now healing wound left wounds now healed." The tation dated 11/8/12: Left ischial wound0.7 10% pink 10%	WO	240	This client's IPP will be updated to reflect his need for repositioning and pressure sor monitoring by 1/7/13. The ser coordinator reviewed all other IPPs to ensure that they are current and accurate. To ensure future compliance, Service Coordinator and Individual Program Coordinator will monitor IPP folders to ensure they contain all information pertinent to individualized care each client on a quarterly basis.	re vice or ure	01/04/2013

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		15G313	B. WIN			12/14/	2012
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			MISSISSIPPI ST NN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Wound clinic no	otation dated 11/15/12:					
	"Wound Clinic:	Non-healing					
	_	neel scabbed overleft					
	ischial wound 0.	6 x 0.5 x					
	0.1cmCellerate	e to ischial wounds every					
	other dayreturn	n in 1 week."					
	Wound clinic no	otation dated 11/29/12:					
	"Wound Clinic:	Non-healing					
		hial wound 0.6 x 0.4 x					
		e to ischial wound every					
		n in 1 weekstage 2					
	1	The 11/29/12 Patient					
	_	s Details (physician's					
		licated "Wound Cleansing					
	· · · · · · · · · · · · · · · · · · ·	ove old dressingCleanse					
	_	normal saline prior to					
		dressing using gauze					
		ues or cotton balls. Do					
		excessive force. Pat dry					
		nges, not tissue or cotton					
		ound and dressing and					
		r. Keep dressing dry and					
	_	dressing every other day.					
		do not wipe off. Apply					
		ch dressing change."					
	An evening obse	ervation was conducted at					
	the group home	on 12/5/12 from 5:10					
		P.M During the entire					
		od client A utilized a					
	_	nobility and was not					
		or redirected to an					
	alternate surface						

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Event ID: PSZ211

Facility ID: 000832

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 14/2012
	PROVIDER OR SUPPLIER		STREET 19038	ADDRESS, CITY, STATE, ZIP O MISSISSIPPI ST DN, IN 46341	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Plan". The 5/12 "[Client A] had a incontinenceD [client A] is at ri related to immod Baseline: [Client almost all the time wheelchair or be transferred out or relieve pressure well as encouraged The 5/12 risk play additional information how/when facility the client and/or wound was to be Confidential into A was reposition he was toileted, at at dinner they wheel chair and couch. When as when client A was	"Repositioning Risk risk plan indicated;				
	conducted at the office on 12/6/12	th LPN #1 and SC #2 was facility's administrative 2 at 2:26 P.M LPN #1 ated client A had a				

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Event ID: PSZ211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN			12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
450.05	NODEL WATER TO INDI				MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	h his buttocks. LPN #1					
		A had a history of					
	-	s the client had a pressure					
		ed on 9/20/12. When					
		staff keep the dressing					
		ering, LPN #1 stated staff					
	•	with saran wrap from					
		LPN #1 indicated there					
	_	rotocol for client A's					
		the wound stayed dry.					
		#2 indicated client A					
	_	himself. LPN #1 and SC					
		nt A's program plan did					
	-	ndicate when the client					
	•	tioned and/or what					
	alternate surface	should be utilized.					
	This federal tag	relates to complaint					
	#IN00119881.	relates to complaint					
	<i>m</i> 11(0011)001.						
	9-3-4(a)						
) 5 1(u)						

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Event ID: PSZ211

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G313	B. WIN			12/14/	2012
NAME OF P	DOMDED OF GLIDNIES				ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	ROVIDER OR SUPPLIER			19038	MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBR	ON, IN 46341		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0318	483.460 HEALTH CARE S	CEDVICES					
		ensure that specific health					
		uirements are met.					
		ation, interview and	W0	318	CONDITION- Please refer to	tag	01/04/2013
		e facility failed to meet			W331	Ü	
		Participation: Health					
		r 2 of 3 sampled clients					
		facility's Health Care					
		ensure the facility's					
		met the nursing needs of					
	_	facility's Health Care					
		ensure the facility's					
		trained staff in regard to					
	_	re needs, to ensure risk					
		all the health care needs					
	-	ng nursing measures staff					
		regard to wound					
		ers. The facility's Health					
	_						
		iled to ensure facility					
	-	health concerns to					
	nursing staff and						
		eeds. The facility's					
		vices failed to ensure					
		assessed, monitored the					
		edical needs at the group					
		cted quarterly nursing					
	assessments.						
	Findings include						
	i maniga merude	•					
	1. The facility's	nursing services failed to					
	=	f the clients in regard to					
		lients' health needs,					
	_	t's pressure ulcer, putting					
	assessing a citch	to prosoure arear, patting					

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN	G		12/14/2012
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SULLER			19038 N	/IISSISSIPPI ST	
	NORTHWEST IND	·		HEBRO	N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	DATE
		risk plans to meet the				
		s of clients, to ensure				
	<u>-</u>	umented medications				
	correctly on the					
		Record and completed				
	skin assessments	s/body checks. The				
	facility's nursing	services failed to ensure				
	staff were adequ	ately trained to provide				
	care/treatment or	f pressure ulcers for client				
	A. Please see W	7331.				
	2. The facility's	nursing services failed to				
	I -	e trained in regard to				
		edication changes on the				
	_	ninistration record (MAR)				
		off were trained in regard				
		n of the client's daily				
		y checks, and to ensure				
		e trained/retrained to				
	<u>-</u>	wounds/pressure ulcers				
	for client A. Ple	•				
	for chent A. Pie	ase see w 342.				
	2 The facility's	nurging correions foiled to				
	1	nursing services failed to				
		ed nurse was available to				
		versee licensed practical				
		nursing staff met the				
		s of a client in regard to				
	pressure ulcers.	Please see W346.				
	1 The facility's	nursing services failed to				
	1	•				
		y nursing assessments for				
		not require a nursing				
	care plan. Pleas	e see W336.				

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Event ID: PSZ211

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

		ATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 12/14	LETED
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC		19038 N	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST N, IN 46341	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST E REGULATORY OR LSC IDENT	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	This federal tag relates to #IN00119881.	complaint				
	9-3-6(a)					

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		15G313	B. WIN			12/14/2	2012
			D. 17111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			DN, IN 46341		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0331	483.460(c)						
	NURSING SERV						
	The facility must provide clients with nursing services in accordance with their needs.						
	i	ation, interview and	W0	221	Community Services Nurse wi		01/13/2013
		·	*** 0.	JJ 1	assess a client's injury/skin	"	01/13/2013
		r 1 of 3 sampled clients			breakdown within 24 hours of		
	` ''	nursing services failed			report. In the event that the		
		s of the clients in regard			individual is at risk for skin bre		
		e client's health needs,			down a work instruction on the		
	assessing a clien	t's pressure ulcer, putting			prevention and monitoring		
	in place specific	risk plans to meet the			Pressure sores was developed 12/7/12. This policy will be	on	
	health care need	of a client, to ensure			revised further to include the		
	facility staff documented medications				identification of all at risk perso	ons.	
	correctly on the				identify methods of preventing		
		Record and completed			skin break down for at risk		
		/body checks. The			persons, and will identify		
		services failed to ensure			measures to be taken for	din l	
					individuals being treated for sk break down. It will be complet		
	•	ately trained to provide			by 1/13/13. Client A's risk plan		
	care/treatment of	pressure ulcers.			was revised on 12/12/12.		
					To prevent further		
	Findings include	:			oversight the quarterly Nursing	9	
					assessment was revised to		
	A review of the	facility's records was			include monitoring of risk plans	I	
	conducted at the	facility's administrative			It was also revised to include a evaluation of the frequency of	all	
		2 at 12:45 P.M Review			future nursing assessments.		
		nvestigation records			Work instructions for this nursi	ng	
	indicated:				assessment will be revised by	~	
	marcatou.				1/31/13.		
	"Investigation E	act Cheat: Cummary and			The service coordinator will		
	_	act Sheet: Summary and			monitor that quarterly nursing	on	
		eident Report Number:			assessments were completed a quarterly basis.	OII	
		on: Neglect failing to			Direct care staff were retrained	,	
		ssessment sheets by staff			on documenting medication	-	
	for consumer wo	ound on buttocks			changes on all clients' MARs		
	areaFacts supp	orting the allegation: All			following each medication cha	nge	
	staff stated that t	hey stopped doing skin			on 12/11/12. Following any		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	IG		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` ') check sheets. (sic)			change DSPs are to fax the Material to the nurse for review. To	AR	
	When notified th	nat the wound healed by			ensure future compliance all th	ıe.	
	the nurse. They	started back doing the			MARs are reviewed by the		
	assessments whe	en notified by MEMO on			Community services nurse on	а	
	10/22/12 that the	ey should not have			monthly basis.		
	stoppedFacts n	ot supporting this			Direct care staff were retrained	1	
	allegation: [Dire	ect Support Professional			on documenting on the skin assessments/body checks on		
	(DSP) #14] state	d that she didn't receive a			12/11/12. These documents a	re	
		nurse regarding skin			to be faxed into the nurse on a		
	assessment check	ksAll the staff that was			weekly basis for review and the	en	
	(sic) interviewed	I stated that they were			forwarded to the service coordinator. To ensure future		
		ssion that they could stop			compliance the service		
	-	ssessment sheets, because			coordinator will track the		
	_	ealed, until they received			completion of these forms to		
		2/12 stated that they			ensure that no skin		
		cop (sic) doing the skin			assessment/body check is missed on a weekly basis.		
		ts and needed to start			Thissed off a weekly basis.		
		vas (sic) unaware of the					
		til they receive (sic) a					
		The nurse [Licensed					
		(LPN) #1] stated that 'she					
		e that she wanted to stop					
		ent checks, but she didn't					
	•	taff to let them know that					
	she wanted to co						
	assessment check	ks.'"					
		f the investigation record					
	indicated:						
	"Conclusion: Pa	arts of this allegation is					
	(sic) true (sic) sta	aff forgot to do skin					
	assessment check	ks. The nurse [LPN #1]					
	was unclear with	her instructions to staff					
	"Conclusion: Pa (sic) true (sic) sta assessment check	aff forgot to do skin ks. The nurse [LPN #1]					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G313	A. BUI B. WIN	LDING IG		12/14/	/2012
NAME OF F	PROVIDER OR SUPPLIER	\ {			DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC. THE			/IISSISSIPPI ST N, IN 46341		
		TATEMENT OF DEFICIENCIES		ID	11, 111 +05+1		(VE)
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	regarding the sk	in assessment checks.					
	She didn't tell st	aff to continue or					
		cking the buttock. Once					
		nealed around September					
		Therefore, staff assume					
	l ' '	asn't suppose (sic) to					
		sessment checks until the					
		22/12 stated that they					
		tinue (sic) doing the skin					
		ksRecommendations:					
	Skin assessments were completed. Further however, not showing anything in						
		nvestigation (sic). A					
		ing wounds and other skin					
	1 -	s to be discussed."					
	conditions needs	s to be discussed.					
	An evening obse	ervation was conducted at					
	the group home	on 12/5/12 from 5:10					
	P.M. until 8:10 l	P.M During the entire					
	observation peri	od client A utilized a					
		nobility and was not					
		or redirected to an					
	alternate surface	or position.					
	A ravious of alia	nt A's record was					
		facility's administrative					
		2 at 11:22 A.M Review					
		and clinic records					
		a history of pressure					
		to 9/20/12. Review of					
		ic records indicated the					
	following:						
	Wound clinic no	otation dated 9/20/12:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G313	B. WIN			12/14/2	2012
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST IND	IANIA INIC. THE			MISSISSIPPI ST		
		·		<u> </u>	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		Now healing wound left		1710			DITTE
		wounds now healed."					
	iscillar and groin	woulds now nealed.					
	Wound clinic no	station dated 11/8/12:					
		Left ischial wound0.7					
	x 0.4 x 0.1cm9						
	yellowFoot- 0.	-					
	-	g left ischial wound and					
		d." Further review of the					
	•	ndicate any nursing					
		the size, shape and color					
		anging of dressing or					
	· · · · · · · · · · · · · · · · · · ·	by facility nursing staff of					
	client A's wound						
	eneme its wounce	••					
	Wound clinic no	station dated 11/15/12:					
	"Wound Clinic:						
		neel scabbed overleft					
	ischial wound 0.						
		e to ischial wounds every					
		n in 1 week." Further					
	1	cord failed to indicate any					
		ment of the size, shape					
		wound, changing of					
		mentation by facility					
		client A's wound.					
	Wound clinic no	tation dated 11/29/12:					
	"Wound Clinic:	Non-healing					
	woundsleft isc	hial wound 0.6 x 0.4 x					
	0.1cmCellerate	e to ischial wound every					
	other dayreturn in 1 weekstage 2						
	<u>-</u>	Further review of the					
	-	ndicate any nursing					
1			1				

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Event ID: PSZ211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	IG		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the size, shape and color					
	· · · · · · · · · · · · · · · · · · ·	anging of dressing or					
		y facility nursing staff of					
	client A's wound	l .					
	FFI 11/20/12 =	at a great to great and a					
		tient Visit Instructions					
	Details sheet (ph	-					
		nd Cleansing Dressing:					
		ssingCleanse the wound					
		ne prior to applying a					
	1	sing gauze sponges, not					
		balls. Do not scrub or					
	use excessive for	rce. Pat dry using gauze					
	sponges, not tiss	ue or cotton balls.					
	Protect wound as	nd dressing and may take					
	shower. Keep di	ressing dry and intact.					
	Change dressing	every other day.					
	Cellerex applied	do not wipe off. Apply					
	new ointment ea	ch dressing change."					
		nart dated 12/6/12:					
		n: Left ischial. Wound					
		Ulcer. Date Acquired:					
	7/12/12. Wound	Status; Not Healed.					
	Measurements:	0.4 x 0.4 x 0.1 cm.					
	Stage: Stage 2."						
		group home Medication					
		Record (MAR) book was					
		/5/12 at 6:00 P.M					
	Review of the record indicated:						
		ety Memo" dated					
	10/31/12, from I	LPN #1 to group home					

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER			19038 M	DDRESS, CITY, STATE, ZIP CODE IISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	[client A]'s right foot with peroxicantibiotic ointme on the area. Kees skin begins to brimmediately." "Health and Safe from LPN #1 to "[Client A] was today for 2 wour and one above heack with the follinght foot wound applied to wound applied to wound THE DRESSING wet-Cover the disathingFor the wound: Cellered clinic. Keep are while bathing. No applied every off 11/10/12. Remowith a damp gaudry gauze. DO NOLD MEDICAT of Cellerex and off cellerex and dressing. Keep a while bathing. To THER DAY (South and the state of	ent to area. Put a bandage ep site clean and dry. If eak down notify me ety Memo" dated 11/8/12 group home staff: seen at the wound clinic eds. One on his right foot is left buttocks. He came slowing orders: For the last Aquacel dressing ed-DO NOT REMOVE G-Do not get the dressing ressing while left ischial (buttocks) applied today by wound a clean and dry. Cover New Cellerex to be mer day, starting Saturday, eve dressing, pat wound ze, then pat dry with a NOT WIPE OFF THE TION. Apply new layer cover with a clean area clean and dry. Cover this is to be done EVERY Saturday, Monday and I return to the wound					

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	TOF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED
	PROVIDER OR SUPPLIER		<i>5.</i> ((2)	STREET A 19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	11/30/12 from L staff: "[Client A clinic on yesterd his right foot and buttocks (sic). If following orders wound: This are the left ischial (bapplied on 11/29 area clean and dr. New Cellerex to day. Remove dr. damp gauze, and gauze. DO NOT MEDICATION. Cellerex and cov. If you need more pharmacy and reany questions. The Further review of 12/5/12 at 6:00 Figure current MAR data 12/31/12. Review "Mupirocin 2% continuentApply daily as directed indicated this meand administered on failed to indicate the red indicated the red indicated the red indicated to indicate the red indicated the red	f the record conducted on P.M., indicated a most ted 12/1/12 until w of the MAR indicated: bintment: Bactroban 2% to wound topically once					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY TPLETED 14/2012	
	PROVIDER OR SUPPLIER		STREE 1903	ET ADDRESS, CITY, STATE, ZIP 8 MISSISSIPPI ST RON, IN 46341	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION'S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	saline solution at on MAR. The recurrent "Health I dated 1/17/12 what risk for skin be incontinence and Client is allergic result in skin irriwetter. Reposition hours and as nee chair if possible, every two hours Encourage client frequently. App Notify nurse of commediately, if a opens, bleeding, client to use the during the day at Disciplinary Teat quarterly and revelient is using the undergarment to adhesives. Servit monitor behavior as needed. Nurs accident reports. On 12/6/12 at 3:: Submitted a 5/12 Plan". The 5/12 "[Client A] had a	avoid contact with the Coordinator to r logs monthly and revise the to monitor incident and and revise as needed." 37 P.M SC #1 "Repositioning Risk risk plan indicated;				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN			12/14/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
		isk for skin breakdown					
		bility and incontinence.					
	_	nt A] currently spends					
		ne he is awake in his					
		ed. He needs to be					
		of his chair and/or bed to					
	_	on his back/buttocks as					
	_	ge muscle movement."					
	_	an indicated: "Staff are to					
	notify the Nurse						
		iny redness, openings or					
	1	rved." The 5/12 risk plan					
	failed to indicate	•					
		egard to how facility staff					
		the clients wound and/or					
		ound was to be kept dry					
	during showers.						
	_	12 risk plan also failed to					
		e facility reviewed and/or					
	_	nt's risk plan to ensure the					
	client's wound c	are needs.					
		Support Plan (ISP) dated					
		d client A was at risk for					
		Client A's record					
	neglected to indi	icate a					
	_	ernative seating schedule					
		ent potential injury. The					
	record failed to i	indicate a current Physical					
	Therapy (PT) as	sessment. The record					
	failed to indicate	e the nursing services					
	obtained a whee	lchair assessment for					
	client A and/or a	a current "Nutritional					
	Assessment" as	the most current					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER		P. W.E.	STREET A 19038 N	ODDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	record indicated	dated 8/21/11. Client A's the nursing services a risk plan for client A's					
	progress notes di was conducted of The 11/25/12 pro "Ate breakfast, s Relaxed watched lunch, hygiene, to nap. He was chabutt was redressed bed, took HS (be sleepChecked changed him as indicated no doccompleted on 11 11/9/12, 11/10/1 11/21/12, 11/22/11/30/12. Revie indicated the grodocument any modient A's wound A review of the training records 12/6/12 at 1:54 H 8/15/12 "Wound neglected to indicated to wound care. It	/1/12, 11/7/12, 11/8/12, 2, 11/17/12, 11/18/12, 12, 11/23/12 and w of the records oup home staff failed to edical status in regards to I daily. facility's group home staff was conducted on P.M Review of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ds to wound care since					
	8/15/12.						
		th DSP #2 was conducted					
		ne on 12/5/12 at 6:18					
		M DSP #2 indicated					
		d treatments to the wound					
		on Mondays, Wednesdays					
		bedtime. DSP #2					
		lient was wet they would					
	change the band	age when he was toileted.					
	When DSP #2 w	as asked if staff at the					
	group home wer	e applying the Cellerex or					
	Mupirocin to cli	ent A's wound, DSP #2					
	indicated the Cel	llerex was being applied.					
	When asked wha	at the Mupirocin was					
	being administer	red for, DSP #2 indicated					
	the Mupirocin w	as applied to client A's					
	wound.	••					
	An interview wi	th the group home Team					
	Lead (TL) was c	onducted at the group					
	` ′	2 at 6:47 P.M The TL					
		ex was being applied to					
		l. When asked what					
		peing applied to, the TL					
	_	om." When asked if the					
		he same as the Cellerex,					
	-	m not sure." When asked					
	to see the Cellerex and the Mupirocin,						
	DSP #2 and the group home TL were not						
	able to locate the medications in the						
	medication file cabinet until 7:15 P.M						
		edication ointment tube					
	THE COHETEX HIE	dication ominicit tuot					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14 /	ETED	
	OF PROVIDER OR SUPPLIER		 19038 N	NDDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	•	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG	was found in a contained packa. Cellerex was not was found in a laindicated it was wound once dail. Confidential into wound "was the Confidential into often client A's wound checked who changed." Confidential into other day. We cand checked who changed." Confidential into wound interview stated Confidential into did not attend the was not notified two months ago, the nurse came to confidential into never seen her a when asked how what the area look interview C state email her skin grindicate where it	erview C stated client A's	TAG	DEFICIENCY)		DATE

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO	ONSTRUCTION 00	COM	TE SURVEY MPLETED 14/2012	
		100010	B. WING			14/2012
NAME OF I	PROVIDER OR SUPPLIEF	t		ADDRESS, CITY, STATE, ZIP C	CODE	
400.05	NODEL IMPORTANT	IANIA INIC. THE		MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE	HEBRO	ON, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		erview C indicated client				
	•	ned out of his chair when				
	-	and some time after he				
	<u> </u>	vould take him out of his				
		he was placed on the				
		ked if staff documented				
		as taken out of his				
	wheelchair, conf	fidential interview stated				
	"No."					
	An interview wi	th Service Coordinator				
	(SC) #1 was con	ducted on 12/5/12 at 7:10				
	P.M. and 12/6/12	2 at 3:55 P.M The SC				
	indicated the Ce	llerex was not on the				
	MAR dated 12/1	/12 to 12/31/12. When				
	the SC was aske	d what the Mupirocin				
		ed to, the SC stated "I				
	0 11	ne SC indicated the				
		be listed on the MAR and				
		document when the				
		g applied. At that time				
	_	hone call. When she				
	_	icated the nurse had				
		he staff to discontinue the				
		further indicated the				
	_	d not be on the MAR.				
	_	d staff were probably				
		• •				
	applying the Cel					
	_	e Mupirocin instead. The				
		ed staff to go find the box				
		s in which she indicated				
		he label. The group home				
		ocate a box or a label. SC				
	#1 indicated LP1	N #1 had conducted a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	COMP	E SURVEY LETED 1/2012	
	PROVIDER OR SUPPLIER		19038 N	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST DN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CCTION	(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	COMPLETION DATE
	wound care at th 2012. SC #1 fur	ds to pressure ulcers and e beginning of November ther indicated there was n in regards to the ng.				
	at the facility's at 12/6/12 at 10:38	th LPN #1 was conducted dministrative office on A.M LPN #1 indicated				
	policy and proce care. When aske	re if the facility had a dure in regard to wound ed if the facility had a o contact a nurse, LPN				
	#1 stated "I have	not seen one."				
	conducted at the office on 12/6/12 and SC #2 indica	facility's administrative 2 at 2:26 P.M LPN #1 ated client A had a				
	indicated client A	A had a history of s the client had a pressure ed on 9/20/12. When				
	was being treated #1 indicated clie	wounds/areas client A d for prior to 9/12, LPN nt A had a wound on his LPN #1 reviewed the				
	9/9/12 "Nursing LPN #1 stated "0	Quarterly Assessment", Oh, he had two areas." d client A's current				
	ulcer was found being treated for	appeared 11/8/12 as the at the wound clinic while a pressure ulcer to his ated "Cellerex is to be				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		15G313	B. WIN			12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ABC OF	NODTUMEST IND	ANA INC. THE			MISSISSIPPI ST		
	NORTHWEST INDI			<u> </u>	N, IN 46341		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		A's] wound every third		1710			DATE
	day, Mondays, V	•					
	"	en asked what Mupirocin					
	1	N #1 stated "I'm not sure					
	· ·	g used for." When LPN					
		wound clinic physicians					
		15/12 and 11/29/12, LPN					
		I the Cellerex should be					
		ner day, and further					
		ex should be on the					
		PN #1 indicated the					
		e told her the Cellerex					
	should be applied						
		Saturdays." When LPN					
	1	here was normal saline					
		ome, LPN #1 stated "No."					
		d the wound care clinic					
		ey did not need to use the					
		lution for client A's					
	wound. When a	sked if LPN #1 sought					
		n the attending physician					
		e wound care clinic nurse,					
		No." When asked if a					
		d gauze square were					
		ame thing, LPN #1 stated					
	"I don't know, th	ere are only gauze					
		uses." LPN #1 then					
	stated "They are	not the same." When					
	asked if LPN #1	had observed staff doing					
		ment at the group home,					
	LPN #1 indicate	d she observed treatments					
	prior to 11/8/12.	When asked if LPN #1					
	_	a's current wound as of					
	11/8/12, LPN #1	stated "No I have not, I					
	l						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14	ETED	
	PROVIDER OR SUPPLIER		p. wii.	STREET A 19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	how big client A LPN #1 stated "A quarter." LPN # to determine the wound clinic not When LPN #1 w went to the group she stated "I was now I have slack she assessed the months at the daindicated skin as done by group he LPN #1 indicate send in the skin at LPN #1 indicate sheets did not girinformation/desc wounds, they on of the wound and who documents medications on t "Lead or staff." to make sure the correctly, LPN # (MAR) to make #1 indicated she 12/2012 MAR. staff keep the dreshowering, LPN "covering with swas told." LPN "vovering with swas told." LPN	ere yet." When asked 's pressure ulcer was, About the size of a 1 indicated she was able size by reading client A's ration dated 11/29/12. The sasked how often she is phome to assess clients, a going quite often, but red." LPN #1 indicated clients every three by program. LPN #1 sessments were to be some staff twice a day. It is did the facility staff were to assessment sheets daily. It is did the skin assessment we any cription of the client's ly indicated the location door injury. When asked the physicians orders and the MAR, LPN #1 stated when asked who checks MAR is documented to stated "The fax to me sure it is correct." LPN had not seen client A's when asked how does essing dry during #1 stated staff were aran wrap from what I #1 indicated there was no for client A's wound to					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey Pleted 4/2012	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP C MISSISSIPPI ST DN, IN 46341	OODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	SC #2 indicated himself. LPN #1 facility's nursing develop a repositioned, and alternate surface #1 and SC #2 indordered a ROHO bed for client A LPN #1 and SC received a ROHO Monday (12/5/12 indicated the use equipment was in program plan. L bed was "electric staff were not to the bed. When a trained on the us stated "Not sure. LPN #1 indicated document any spregards to client status. LPN #1 in have a current Prassessment or nuregards to client When asked if clirisk plan for skin stated "I don't knrisk plans." When	d stayed dry. LPN #1 and client A could reposition and SC #2 indicated the services failed to tioning schedule which he client should be dor indicate what should be utilized. LPN dicated the wound clinic ocushion and a hospital due to his pressure ulcers. #2 indicated client A D cushion and bed on 2). LPN #1 and SC #2 of the adaptive to part of client A's PN #1 stated client A's pal" and further indicated change the settings on sked if staff had been to of the bed, LPN #1 I did not train them." I did not train them." I did not train them. I did not grain assessment in A's medical/wound ndicated client A did not part of client A did not passessment in A's medical/wound ndicated client A did not passessment in A's wound care needs. I ient A had an updated a breakdown, LPN #1 ow, I don't have access to be a sked if nursing staff and had input in the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	PLETED 4/2012
	PROVIDER OR SUPPLIEF		19038	ADDRESS, CITY, STATE, ZIP MISSISSIPPI ST DN, IN 46341	CODE	
ARC OF (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR development of clients, LPN #1 all risk plans for	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) medical risk plans for stated "No, the SC write			SHOULD BE	(X5) COMPLETION DATE

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Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	(3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G313				12/14/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF 1		ANA INC. THE			MISSISSIPPI ST		
ARC OF I	NORTHWEST INDI	ANA INC, THE		ПЕВКО	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0336	483.460(c)(3)(iii)						
	NURSING SERV						
	Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status						
	•	w or their nealth status a quarterly or more					
		pending on client need.					
	-	ew and record review for	W0336 Quarterly nursing asses		Quarterly nursing assessment	e	01/04/2013
		lients (B), the facility's	""	550	for client B was completed on		01/04/2013
	•	•			12/8/12. All other clients nursi	ng	
	•	failed to conduct			assessments were also		
		g assessments for clients			completed in December 2012.		
	who did not requ	iire a nursing care plan.			The quarterly Nursing		
					assessment was revised to		
	Findings include:				include monitoring of risk plans. It was also revised to include an		
	, and the second					an	
	Client B's record	was reviewed on			evaluation of the frequency of		
						na	
						9	
					1/31/13.		
		•			To ensure future compliance to	he	
	on 2/9/12. Clien	t B's 1/11/12 Individual			•	r	
	Program Plan (II	PP) indicated the client					
	did not require a	medical care plan.				on	
	Client B's 11/12	physician's orders			a quarterly basis.		
		· ·					
	· ·	•					
	_	•					
	Hypertension, G	astroesophageal Reflux					
	Disorder and Ma	ijor Depressive Disorder.					
	Interview with I	PN #1 on 12/6/12 at 2:26					
	•						
	been completed	III 3/12 and 8/12. LPN #2					
	indicated a nursi examination/asses on 2/9/12. Clien Program Plan (II did not require a Client B's 11/12 indicated the clien medications. Client and Client B's 11/12 indicated the client medications. Client B's 11/12 indicated the client medicated the client medicated and client B's 11/12 indicated the client medicated the client medicated the client medicated and client B's 11/12 indicated the client medicated th	essment was completed at B's 1/11/12 Individual PP) indicated the client medical care plan. physician's orders ent received routine ient B's 11/12 physician's client B's diagnoses re not limited to, sorders, Constipation, astroesophageal Reflux ajor Depressive Disorder.			future nursing assessments. Work instructions for this nursi assessment will be revised by 1/31/13.	ne r	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00		TE SURVEY MPLETED 14/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	indicated she could not locate any additional nursing quarterly assessments for the client.						
	9-3-6(a)						

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Event ID: PSZ211

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G313	B. WIN			12/14/	2012
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER				MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	DN, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0342	483.460(c)(5)(iii) NURSING SERV	ICES					
		must include implementing					
	with other members of the interdisciplinary team, appropriate protective and preventive						
		that include, but are not					
	_	direct care staff in					
	detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness,						
		equired to meet the health					
	needs of the clier						
	Based on observ	ation, interview and	W0	342	Direct care staff were retrained	t	01/04/2013
	record review for	r 1 of 3 sampled clients			on documenting medication		
	(A), the facility's nursing services failed to ensure staff were trained in regard to				changes on all clients' MARs following each medication cha	nae	
					on 12/11/12. Following any	nge	
	documenting me	dication changes on the			change DSPs are to fax the M	AR	
	Medication Adm	ninistration record (MAR)			to the nurse for review. To ensure future compliance all the MARs are reviewed by the		
	and to ensure sta	ff were trained in regard					
	to documentation	n of the client's daily			Community services nurse on	а	
	notes and/or bod	y checks, and to ensure			monthly basis.	-	
	facility staff wer	e trained/retrained to			Direct care staff were retrained	t	
	provide care for	wounds/pressure ulcers.			on documenting on the skin		
					assessments/body checks on 12/11/12. These documents a	ire	
	Findings include	:			to be faxed into the nurse on a		
					weekly basis for review and th	en	
	A review of the	facility's records was			forwarded to the service		
		facility's administrative			coordinator. To ensure future compliance the service		
		2 at 12:45 P.M Review			coordinator will track the		
		nvestigation records			completion of these forms to		
	indicated:	8			ensure that no skin		
					assessment/body check is		
	"'Investigation F	act Sheet: Summary and			missed on a weekly basis.		
	_	eident Report Number:					
		on: Neglect failing to					
	_	ssessment sheets by staff					
	for consumer wo	_					
	101 Consumer Wo	ound on outlocks					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A 19038 N	DDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	staff stated that the assessments (sich When notified the the nurse. They assessments when 10/22/12 that the stoppedFacts in allegation: [Dire (DSP) #14] state memo from the massessment check (sich) interviewed under the impression doing the skin as the wound had head memo on 10/22 shouldn't have stassessment sheet backAll staff viscond injury under memo on 11/8 Practical Nurse (told a few people the skin assessment check shouldn't have stassessment sheet back assessment sheet back assessment check Practical Nurse (told a few people the skin assessment check shouldn't have stassessment check shouldn't have stassessment sheet back to the sign assessment check. Further review of indicated:						

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Facility ID: 000832

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN			12/14/2012
NAME OF F	DROVIDED OD GLIDDI IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			19038 N	MISSISSIPPI ST	
	NORTHWEST IND	·			N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		,	-	TAG	BEIGERET	DATE
		ks. The nurse [LPN #1]				
		her instructions to staff				
	regarding the skin assessment checks.					
	She didn't tell staff to continue or					
		king the buttock. Once				
	the wound was healed around September					
	22, 2012 (sic). T	Therefore, staff assume				
	(sic) that they wa	asn't suppose (sic) to				
	continue skin ass	sessment checks until the				
	email dated 10/2	2/12 stated that they				
	should have com	tinue (sic) doing the skin				
	assessment checksRecommendations:					
	Skin assessment	s were completed.				
		, not showing anything in				
		nvestigation (sic)"				
	An evening obse	ervation was conducted at				
	the group home	on 12/5/12 from 5:10				
	P.M. until 8:10 I	P.M During the entire				
	observation perio	od client A utilized a				
	wheelchair for m	nobility and was not				
	encouraged and/	or redirected to an				
	alternate surface	or position.				
	A review of clien	nt A's record was				
	conducted at the	facility's administrative				
		2 at 11:22 A.M Review				
		and clinic records				
		a history of pressure				
		to 9/20/12. Review of				
		ound Clinic record				
		nd Clinic: Non-healing				
		hial wound 0.6 x 0.4 x				
I	U.1cmCellerate	e to ischial wound every				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO	00	COM	TE SURVEY MPLETED 14/2012	
		100010	B. WING			14/2012
NAME OF I	PROVIDER OR SUPPLIEF	t .		ADDRESS, CITY, STATE, ZIP	CODE	
4DC OF	NODTI IMECT IND	IANIA INIC. THE		MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE	ПЕВКО	DN, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO.		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	,	n in 1 weekstage 2				
	_	The 11/29/12 Patient				
	Visit Instruction					
	(physician's orde	ers) indicated "Wound				
	Cleansing Dress	ing: Remove old				
	dressingCleans	se the wound with normal				
	saline prior to ap	oplying a clean dressing				
	using gauze spor	nges, not tissues or cotton				
	balls. Do not scrub or use excessive					
force. Pat dry using gauze sponges, not tissue or cotton balls. Protect wound and						
	dressing and may take shower. Keep					
	_	intact. Change dressing				
		Cellerex applied do not				
	1 -	new ointment each				
	dressing change.					
	diessing change.	•				
	A review of the	group home Medication				
	Administration I	Record (MAR) book was				
	conducted on 12	/5/12 at 6:00 P.M				
	Review of the re	ecord indicated:				
	"Hoolth and Cat	Satu Mama" datad 11/0/12				
		Sety Memo" dated 11/8/12				
		group home staff:				
		seen at the wound clinic				
	_	nds. One on his right foot				
		is left buttocks. He came				
		llowing orders: For the				
		l: Aquacel dressing				
		d-DO NOT REMOVE				
	THE DRESSING	G- Do not get the dressing				
	wet-Cover the d	ressing while				
	bathingFor the	e left ischial (buttocks)				
	wound: Cellere	x applied today by wound				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	a clean and dry. Cover					
	_	New Cellerex to be					
	applied every other day, starting Saturday,						
		ve dressing, pat wound					
		ze, then pat dry with a					
		NOT WIPE OFF THE					
	OLD MEDICATION. Apply new layer						
	of Cellerex and cover with a clean						
	dressing. Keep a	area clean and dry. Cover					
	while bathing. This is to be done EVERY						
	OTHER DAY (Saturday, Monday and						
	Wednesday) he'll return to the wound						
	clinic on Thursd						
	"Health and Safe	ety Memo" dated					
		PN #1 to group home					
] was seen at the wound					
	-	ay for 2 wounds. One on					
		I one above his left					
	_	Ie came back with the					
	` ′	: For the right foot					
	_	ea has been resolved. For					
		outtock) wound: Cellerex					
	*	by wound clinic. Keep					
	* *	•					
		ry. Cover while bathing.					
		be applied every other					
	_	essing, pat wound with					
	10	then pat dry with dry					
	_	WIPE OFF THE OLD					
		Apply new layer of					
	Cellerex and cov	er with a clean					
	dressing"						
	Further review o	f the record conducted on					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY IPLETED 14/2012	
	PROVIDER OR SUPPLIER		STREET A 19038 N	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST NN, IN 46341	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	current MAR da 12/31/12. Revie "Mupirocin 2% o ointmentApply daily as directed indicated this me administered on and 12/5/12. Th administered on failed to indicate ointment was to review of the Masaline solution at on MAR. The record indic "Health Risk Pla 1/17/12 which ir for skin breakdo incontinence and Client is allergic result in skin irri wetter. Repositi hours and as nee chair if possible. every two hours Encourage client frequently. App Notify nurse of o	w of the MAR indicated: pintment: Bactroban 2% to wound topically once." Further review edication was 12/1/12, 12/3/12, 12/4/12 is medication was not 12/2/12. The record which wound this be applied to. Further AR did not have Cellerex, and gauze squares listed atted a most current an" for client A dated adicated: "Client is at risk was related to a decreased activity. To adhesives which can tation. Client is a heavy oned (sic) client every 4 ded. Position in another Check for incontinence and change as needed. It to change positions by treatment as ordered. Changes in skin condition area becomes reddened, or irritated"				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	ľ ′	TE SURVEY IPLETED
		15G313	A. BUILDING			14/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CO		
NAME OF F	PROVIDER OR SUPPLIEF	L Comment		MISSISSIPPI ST	JDE	
ARC OF	NORTHWEST IND	IANA INC, THE		N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE PPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		"Repositioning Risk				
		risk plan indicated;				
	"[Client A] had	_				
		ue to these conditions				
	[client A] is at ri	sk for skin breakdown				
	related to immob	pility and incontinence.				
	Baseline: [Clien	t A] currently spends				
	almost all the tin	ne he is awake in his				
	wheelchair or be	d. He needs to be				
	transferred out o	f his chair and/or bed to				
	relieve pressure	on his back/buttocks as				
	well as encourage muscle movement."					
	The 5/12 risk pla	an indicated: "Staff are to				
	notify the Nurse	and the Service				
	Coordinator of a	ny redness, openings or				
	bleeding is obser					
	A review of the	group home daily				
	progress notes d	ated 9/1/12 to 11/30/12				
	was conducted o	on 12/6/12 at 1:15 P.M				
	The 11/25/12 pro	ogress note indicated:				
	_	howered took a.m. meds.				
	-	l t.v. after goals. After				
		took noon med, took a				
	1 / 30 /	anged for dinner, sore on				
		ed. He clean (sic) for				
		edtime) meds, went to				
		him every two hours				
		needed." Further review				
	indicated no doc					
		/1/12, 11/7/12, 11/8/12,				
	•	2, 11/17/12, 11/18/12,				
	· ·	12, 11/123/12 and				
	-	w of the records				
	11/30/12. KeVie	w of the records				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMI	e survey Pleted 4/2012
	PROVIDER OR SUPPLIER		STREET 19038	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST ON, IN 46341	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		oup home staff failed to dedical status in regards to daily.				
	training records 12/6/12 at 1:54 I 8/15/12 "Wound indicate DSP #2 had been trained Nursing Services and/or conduct a regards to wound An interview wir at the group hom P.M. and 6:34 P client A received on his buttocks of and Saturdays at indicated if the of change the band When DSP #2 w group home wer Mupirocin to clie indicated the Ce When asked what being administer	facility's group home staff was conducted on P.M Review of the Care Training" did not DSP #12 and DSP #15 in regards to wound care. It is failed to document any additional training in did care since 8/15/12. The DSP #2 was conducted the on 12/5/12 at 6:18 in DSP #2 indicated did treatments to the wound on Mondays, Wednesdays to bedtime. DSP #2 indicated did treatments to the would age when he was toileted. The assked if staff at the did age when he was toileted. The applying the Cellerex or ent A's wound, DSP #2 illerex was being applied. The Mupirocin was the did for, DSP #2 indicated are applied to client A's				
	Lead (TL) was c	th the group home Team conducted at the group 2 at 6:47 P.M The TL				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		12/14/	2012
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ex was being applied to					
		l. When asked what					
	Mupirocin was being applied to, the TL stated "His bottom." When asked if the Mupirocin was the same as the Cellerex,						
	the TL stated "I'm not sure." When asked						
	to see the Cellerex and the Mupirocin,						
	DSP #2 and the group home TL were not						
	able to locate the medications in the medication file cabinet until 7:15 P.M						
	The Cellerex medication ointment tube						
	was found in a clear plastic bag, which						
	contained packa	ged gauze squares. The					
	Cellerex was no	t labeled. The Mupirocin					
	was found in a la	abeled box which					
	indicated it was	to be applied topically to					
	wound once dail						
	Confidential into	erview C stated client A's					
	wound "was the	size of a dime."					
	Confidential inte	erview C stated client A's					
		little open." When					
		rview C was asked how					
		wound area was changed,					
		rview C stated "Every					
		heck when he is toileted					
	_	en given shower and					
		idential interview C also					
	_	se square gauze and tape.					
	1	en the staff was trained in					
		care, confidential					
	~	"I read a memo."					
		erview C indicated she					
	aid not attend th	e training because she					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G313	B. WIN	G		12/14/2012	
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			19038 N	/IISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		of the training held about					
	two months ago.						
	An interview with Service Coordinator (SC) #1 was conducted on 12/5/12 at 7:10						
	P.M. and 12/6/12	2 at 3:55 P.M The SC					
	indicated the Cel	llerex was not on the					
	MAR dated 12/1	/12 to 12/31/12. When					
	the SC was asked	d what the Mupirocin					
	was being applied to, the SC stated "I						
	don't know." The SC indicated the Cellerex should be listed on the MAR and						
	the staff should o	document when the					
	Cellerex is being	g applied. At that time					
	_	hone call. When she					
	•	cated the nurse had					
		he staff to discontinue the					
	-	urther indicated the					
	•	d not be on the MAR.					
	_	d staff were probably					
	applying the Cel						
		Mupirocin instead. The					
	_	ed staff to go find the box					
		in which she indicated					
		ne label. The group home					
		ocate a box or a label. SC					
		N #1 had conducted a					
		ds to pressure ulcers and					
		e beginning of November					
		ther indicated there was					
		n in regards to the					
	mentioned meeti	ng.					
	An interview with	th LPN #1 and SC #2 was					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE C	OONSTRUCTION OO	COM	TE SURVEY IPLETED 14/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CO		
NAME OF I	PROVIDER OR SUPPLIER			MISSISSIPPI ST	ODL	
ARC OF	NORTHWEST INDI	ANA INC, THE	HEBR	ON, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		facility's administrative				
		2 at 2:26 P.M LPN #1				
		nted client A had a				
	_	his buttocks. LPN #1				
		A had a history of				
		s the client had a pressure				
		ed on 9/20/12. LPN #1				
		A's current pressure ulcer				
		12 as the ulcer was found				
	at the wound clinic while being treated for					
		to his foot. LPN #1				
	stated "Cellerex is to be applied to [client					
	-	y third day, Mondays,				
	1	Saturdays." When asked				
	-	was used for, LPN #1				
		are what that is being				
		LPN #1 reviewed the				
		ysicians orders dated				
		29/12, LPN #1 then				
		llerex should be applied				
	'	and further indicated				
		be on the current MAR.				
	When asked who					
		s and medications on the				
	· ·	tated "Lead or staff."				
		checks to make sure the				
		nted correctly, LPN #1				
		o me (MAR) to make				
		" LPN #1 indicated she				
		nt A's 12/2012 MAR.				
		#2 indicated the wound				
		ROHO cushion and a				
	_	client A due to his				
	pressure ulcers.	LPN #1 and SC #2				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		00	COMPLETED 12/14/2012	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
	indicated client A received a ROHO cushion and bed on Monday (12/5/12). LPN #1 and SC #2 indicated the use of the adaptive equipment was not part of client A's program plan. LPN #1 stated client A's bed was "electrical" and further indicated staff were not to change the settings on the bed. When asked if staff had been trained on the use of the bed, LPN #1 stated "Not sure. I did not train them." This federal tag relates to complaint #IN00119881. 9-3-6(a)				

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Event ID: PSZ211

Facility ID: 000832

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G313	B. WIN			12/14/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	MISSISSIPPI ST		
	NORTHWEST INDI				N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0346	483.460(d)(4) NURSING STAFF						
		es only licensed practical or					
		to provide health services, mal arrangement with a					
		to be available for verbal or					
		n to the licensed practical					
		ation, interview and	$ _{W0}$	346	This tag is in error as a		01/04/2013
		r 1 of 3 sampled clients	""	J 10	Registered Nurse has been on	1	01/07/201 <i>3</i>
	(A), the facility f	•			staff and available to nursing s		
					and regularly reviewed		
	_	was available to consult			documentation. 1/16/13Per yo		
		censed practical nurses to			request of a written employme	nt	
	_	taff met the health care			verification regarding Marsha Clark. She was a Registered		
	needs of a client	in regard to pressure			Nurse and her job title was the	1	
	ulcers.				The Director of Health Services.		
					Her employment was from		
	Findings include	:			8/22/11 to 12/27/12. Please re	fer	
	C				to attachment from Human		
	A review of the t	facility's records was			Resources.		
		facility's administrative					
		2 at 12:45 P.M Bureau					
	•	al Disabilities Services					
	, , ,	ated 11/8/12Date of					
		8/12Submitted Date:					
	_	t A] was on scheduled					
	medical appointr	ment to the wound clinic					
	for a blister on h	is foot. Staff at the					
	wound clinic per	formed a routine body					
	_	a 0.7 x 0.4 x 0.1 cm					
		on his left ischium					
	(buttocks)."	on mb fort ibellium					
	(buttocks).						
	RDDS report dat	ted 11/8/12Date of					
	•	12/12Submitted date:					
	Kilowicuge. 11/	12/12Subilituou uato.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G313	B. WING		12/14/2012
NAME OF T	DROWNER OF GLIBBY TEX			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF		19038	MISSISSIPPI ST	
ARC OF	NORTHWEST IND	IANA INC, THE	HEBR	ON, IN 46341	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	1	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	`	PN #1) was made aware			
	of this incident of	on this consumer after			
	which I had sent	him (client A) to the			
	wound clinic on	November 8, 2012.			
	While doing a ro	outine body check the			
	doctor found a 0	.7 x 0.4 x 0.1cm pressure			
	wound on his le	ft ischium (buttock). On			
	October 22, 201	2 staff was instructed to			
	continue with do	oing the skin assessment			
		ff failed to document any			
	wound findings"				
	Review of the fa	cility's investigation			
	records indicated				
	"'Investigation F	act Sheet: Summary and			
	_	eident Report Number:			
		on: Neglect failing to			
		ssessment sheets by staff			
		ound on buttocks			
		oorting the allegation: All			
		they stopped doing skin			
	,) check sheets. (sic) nat the wound healed by			
		J			
	_	started back doing the			
		en notified by MEMO on			
		ey should not have			
		not supporting this			
	1 -	ect Support Professional			
	. , -	ed that she didn't receive a			
memo from the nurse regarding skin					
	assessment checksAll the staff that was				
	(sic) interviewed	l stated that they were			
	under the impres	ssion that they could stop			
	I.			1	

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Event ID: PSZ211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G313	B. WING		12/14/2012
NAME OF E	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
				MISSISSIPPI ST	
ARC OF	NORTHWEST IND	IANA INC, THE	HEBR	ON, IN 46341	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	ssessment sheets, because			
		ealed, until they received			
		2/12 stated that they			
		top (sic) doing the skin			
		ts and needed to start			
		vas (sic) unaware of the			
	1	til they receive (sic) a			
		.The nurse [Licensed			
		(LPN) #1] stated that 'she			
		e that she wanted to stop			
	the skin assessm	ent checks, but she didn't			
	get back to the s	taff to let them know that			
	she wanted to co	ontinue the skin			
	assessment chec	ks.'" The facility's			
	investigation inc	licated "Conclusion:			
	Parts of this alle	gation is (sic) true (sic)			
	staff forgot to do	skin assessment checks.			
	The nurse [LPN	#1] was unclear with her			
	instructions to st	aff regarding the skin			
	assessment chec	ks. She didn't tell staff to			
	continue or disco	ontinue checking the			
	buttock. Once the	he wound was healed			
	around Septemb	er 22, 2012 (sic).			
	Therefore, staff	assume (sic) that they			
	wasn't suppose (sic) to continue skin			
		ks until the email dated			
	10/22/12 stated t	that they should have			
		oing the skin assessment			
	, ,	mendations:A system			
		and other skin			
		s to be discussed."			
	An evening obse	ervation was conducted at			
	_	on 12/5/12 from 5:10			
	5 "1			1	

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	EMENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY PLETED 4/2012
	OF PROVIDER OR SUPPLIE		STREET A 19038	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341		
(X4) II PREFI	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
TAC	P.M. until 8:10 observation peri wheelchair for r encouraged and alternate surface A review of clie conducted at the office on 12/6/1 of client A's wo indicated he had ulcers from 3/12 nursing notes fo facility's nurse (monitor and/or e client A's pressu ulcer was discov wound care clin Confidential int wound "was the Confidential int wound "is still a how often the re home, confident have never seen When asked how what the area lo interview C stat email her skin g indicate where i information on the	ent A's record was e facility's administrative 2 at 11:22 A.M Review und clinic records d a history of pressure 2 to 9/20/12. Client A's or 2012 indicated the LPN) did not assess, develop a risk plan for ure ulcer after the pressure wered by a doctor at the	TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	IG		12/14/	2012
NAME OF F	PROVIDER OR SUPPLIEF	\			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODEL IMPORTANT	IANIA INIC. THE			MISSISSIPPI ST		
	NORTHWEST IND				N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		dministrative office on		0			5.112
		A.M LPN #1 indicated					
	she was not aware if the facility had a						
		edure in regard to wound					
		ed if the facility had a					
		to contact a nurse, LPN					
	#1 stated "I have not seen one."						
	An interview wi	th LPN #1 and SC #2 was					
	conducted at the	facility's administrative					
	office on 12/6/12 at 2:26 P.M LPN #1 and SC #2 indicated client A had a						
	pressure ulcer or	n his buttocks. LPN #1					
	indicated client	A had a history of					
		s the client had a pressure					
		ed on 9/20/12. When					
	_	wounds/areas client A					
	_	d for prior to 9/12, LPN					
		ent A had a wound on his					
		LPN #1 reviewed the					
	1	Quarterly Assessment",					
		Oh, he had two areas."					
		PN #1 had observed staff					
	1 -	re treatment at the group					
	· ·	ndicated she observed					
		to 11/8/12. When asked					
		een client A's current					
		8/12, LPN #1 stated "No I					
	· ·	not been there yet." v big client A's pressure					
		#1 stated "About the size					
	-	PN #1 indicated she was					
	_	e the size by reading					
		d clinic notation dated					
	Chem A S Would	i chine notation dated					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE COMPL	
ANDILLAN	OI CORRECTION	15G313		LDING	00	12/14/	
		100010	B. WIN		DDDDGG GWW GG	12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			N, IN 46341		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE PROPERTY		ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		LPN #1 was asked how					
		the group home to					
	•	e stated "I was going					
	_	now I have slacked."					
		d she assessed the clients					
	-	ths at the day program.					
		d skin assessments were					
		oup home staff twice a					
	day. LPN #1 inc	licated the facility staff					
	were to send in t	he skin assessment sheets					
	daily. LPN #1 ir	ndicated the skin					
	assessment sheet	s did not give any					
	information/desc	ription of the client's					
	wounds, they on	ly indicated the location					
	of the wound and	d/or injury. When asked					
	who documents	the physicians orders and					
	medications on t	he MAR, LPN #1 stated					
	"Lead or staff."	When asked who checks					
	to make sure the	MAR is documented					
	correctly, LPN #	1 stated "The fax to me					
	(MAR) to make	sure it is correct." LPN					
	#1 indicated she	had not seen client A's					
		When asked how does					
	staff keep the dre						
	-	#1 stated staff were					
	•	aran wrap from what I					
	_	#1 indicated there was no					
		for client A's wound to					
	•	d stayed dry. LPN #1 and					
		client A could reposition					
		and SC #2 indicated					
		m plan neglected to					
		cate when the client					
		tioned and/or what					
	should be reposi	noned and/or what					

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Event ID: PSZ211

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	СОМ	e survey pleted 4/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
	#1 and SC #2 incordered a ROHO bed for client A LPN #1 and SC received a ROHO Monday (12/5/1) indicated the use equipment was reprogram plan. It bed was "electric staff were not to the bed. When a trained on the use stated "Not sure LPN #1 indicated document any spregards to client status. LPN #1 have a current P assessment or no regards to client When asked if corisk plan for skin stated "I don't know the involved and development of clients, LPN #1 all risk plans for if the facility had available for over #2 stated "No."	should be utilized. LPN dicated the wound clinic of cushion and a hospital due to his pressure ulcers. #2 indicated client A to cushion and bed on 2). LPN #1 and SC #2 of the adaptive not part of client A's part of client A's part and further indicated change the settings on asked if staff had been to e of the bed, LPN #1 I did not train them." I did not train them." I did not train them. I did not precific information in A's medical/wound andicated client A did not assessment, wheelchair attritional assessment in A's wound care needs. The seal of the bed in breakdown, LPN #1 the seal of the precipitation in the medical risk plans for stated "No, the SC write all clients." When asked if a Registered Nurse presight, LPN #1 and SC when asked who was ght and direct supervision						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

	of correction (15G313) PROVIDER/SUPPLIER/CLIA (15G313)	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 14/2012
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	over the facility's LPN staff, LPN #1 stated "[Group Home Services Director name (GHSD)]." When asked if the GHSD was a RN, LPN #1 stated "No."				
	This federal tag relates to complaint #IN00119881.				
	9-3-6(a)				

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